June 22, 2015

The Honorable Larry Phillips
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Phillips:

This letter transmits the first progress report of the Community Alternatives to Boarding Task Force in response to Motion 14225. The motion asked the Task Force, co-convened by the Governor and the King County Executive in fall 2014, to develop sustainable solutions to the psychiatric boarding crisis.

The attached progress report details the work to date by the Task Force to:

- Achieve and maintain compliance with the pivotal 2014 Washington State Supreme Court decision *In re the Detention of D.W. et al.*;
- Increase optimal placement of people detained for involuntary psychiatric treatment under the state's Involuntary Treatment Act (ITA) directly into certified evaluation and treatment (E&T) facilities designed to serve involuntarily committed individuals;
- Reduce and work towards elimination of the use of temporary single bed certification (SBC) detention authority related to capacity issues; and
- Through behavioral health integration and redesign, reduce demand for involuntary care and reduce demand for ITA Court services by supporting the development of a comprehensive service continuum that results in improved behavioral health care throughout the treatment system and across the population.

As the attached report demonstrates, the Task Force collaboratively developed and implemented a range of process improvements within existing resources. This work built on other efforts already under way in King County, and helped to achieve compliance with the Washington State Supreme Court's August 2014 ruling outlawing delay in provision of timely and appropriate mental health treatment for individuals involuntarily committed to inpatient mental health treatment.

The Task Force includes a diverse range of stakeholders engaged with this treatment access crisis, including representatives from the state Division of Behavioral Health and Recovery,

Western State Hospital, Washington State Hospital Association, Harborview Medical Center, Navos, the King County Department of Community and Human Services, Mental Health, Chemical Abuse and Dependency Services Division, King County Superior Court, the King County Prosecuting Attorney's Office, and the King County Department of Public Defense.

Motion 14225 requests the Task Force to review and develop recommendations for short-, medium- and long-term sustainable solutions for early intervention, prevention, and least restrictive alternatives for individuals in mental health and substance abuse crisis. The group continues to develop recommendations, as described in the report. This work will be expanded and developed into recommendations via the Task Force's future reports, due in January and June 2016, respectively.

Addressing this treatment access crisis via collaborative innovation featuring preventive and less restrictive approaches responds primarily to two of the County's strategic plan priorities in the Health and Human Potential domain: protecting the health of communities and ensuring a network of integrated and effective health and human services is available to people in need. In addition, it supports the County's fair and just principle.

It is estimated that this report required 140 staff hours to produce, costing $7,664.

If you have any questions, please feel free to contact Adrienne Quinn, Director, Department of Community and Human Services at 206-263-1491.

Sincerely,

Andi Smith
Senior Policy Advisor
Office of Governor Jay Inslee

Betsy Jones
Health and Human Potential Policy Advisor
Office of King County Executive Dow Constantine

Enclosure

cc: King County Councilmembers
ATTN: Carolyn Busch, Chief of Staff
Anne Noris, Clerk of the Council
Carrie S. Cihak, Chief of Policy Development, King County Executive Office
Dwight Dively, Director, Office of Performance, Strategy and Budget
Adrienne Quinn, Director, Department of Community and Human Services (DCHS)
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King County

Community Alternatives to Boarding Task Force Progress Report

Response to Motion 14225

June 2015

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Executive Summary

The Community Alternatives to Boarding Task Force

To address a mental health community treatment crisis, Governor Jay Inslee and King County Executive Dow Constantine jointly convened the Community Alternatives to Boarding Task Force in August 2014. The growing number of individuals involuntarily detained for inpatient psychiatric care held in temporary settings not designed to serve their mental health needs prompted the Governor and Executive to a call for action. This phenomenon, known as "psychiatric boarding," was also the subject of a Washington State Supreme Court ruling that became effective in December 2014.

The Task Force brought together representatives from the legal, judicial, and treatment systems that impact individuals involved in the involuntary commitment process. The Task Force embraced the challenges of simultaneously working to eliminate the boarding crisis in the near term, while making recommendations regarding the design of a system of care that would prevent its recurrence over the long-term by focusing on prevention, early intervention, less restrictive alternatives, and reduction of involuntary treatment demand.

Motion 14225: Recommendations to Improve the Involuntary Commitment System

Motion 14225 passed by the Metropolitan King County Council on September 15, 2014, requests that the Task Force develop sustainable solutions to the psychiatric boarding crisis. The legislation further asks the Task Force, with assistance from the County Executive, to review and recommend short- and long-term sustainable solutions for prevention, early intervention, and least restrictive alternatives for individuals in mental health and substance abuse crisis[1].

Specifically, the Motion asks the Task Force to develop recommendations that: (a) increase the use of least restrictive alternatives for individuals in behavioral health crisis, thereby reducing demand for involuntary treatment, including the demand for involuntary treatment court services; (b) provide for successful reentry into the community for individuals who have received services from psychiatric hospitals; and (c) focus especially on prevention and intervention services.

The Motion, included as Appendix A, calls for the Task Force to deliver two progress reports and a final report on their work. This report is the Task Force's first progress report called for by the King County Council's legislation.

Scope and Purpose of This Report

As the first of three reports from the Community Alternatives to Boarding Task Force to the King County Council, this document details the progress to date of efforts by the Task Force to:

- Achieve and maintain compliance with the pivotal 2014 Washington Supreme Court decision *In re the Detention of D.W. et al.*;

[1] The terms "mental health" and "substance abuse" are used in the Task Force charter; however, in this report, the term "behavioral health" is used. The term "behavioral health" reflects the integration of mental health and substance abuse into one system of care.

- Increase optimal placement of people detained for involuntary psychiatric treatment under the state's Involuntary Treatment Act (ITA) directly into certified evaluation and treatment (E&T) facilities designed to serve involuntarily committed individuals;
- Reduce and work towards elimination of the use of temporary single bed certification (SBC) detention authority related to capacity issues; and
- Through behavioral health integration and redesign, reduce demand for involuntary care and reduce demand for ITA Court services by supporting the development of a comprehensive service continuum that results in improved behavioral health care throughout the treatment system and across the population.

This report also provides important contextual information, outlining the background and impacts of the involuntary treatment access crisis in King County and Washington in recent years. Improvements and innovations initiated or influenced by the Task Force, as well as coordination with other related work in the community, are detailed in this report.

Approach and Achievements to Date

The Task Force approached its work in two ways. It first quickly determined and began implementing near-term improvements to immediately address the Washington State Supreme Court decision, while simultaneously developing long-term re-design of certain key elements of the system for the purpose of diversion when appropriate.

Immediate system and procedural improvements initiated by the Task Force to date are noted below. Each of these actions was intended to increase efficiency and effectiveness in the system. They include the following activities:

- Extending patient placement hours with centralized coordination;
- Establishing structured guidelines for patient placement to match patients to the appropriate treatment setting;
- Establishing communication lines between inpatient psychiatric facility executives and the County to expedite placement when necessary;
- Beginning to centralize capacity tracking and reporting for King County's involuntary psychiatric beds;
- Streamlining single bed certification approval processes at Western State Hospital (WSH) that had caused delays;
- Increasing collaboration at the Involuntary Treatment Court;
- Engaging community hospitals to assist with this treatment access crisis by agreeing to care for patients even under new, stricter guidelines from the state; and
- Dramatically increasing the rate at which involuntary patients are directly and immediately placed into appropriate facilities for treatment.

The Task Force and its many community partners have worked together to end psychiatric boarding in King County. Along with its near-term activities, the Task Force is also focusing on redesigning certain key elements of the system, with an intentional focus on prevention-oriented strategies that will lead to sustainable change. Long-term system redesign efforts to date have included:

- Envisioning system improvements beyond the typical constraints of current systems;
- Rigorous environmental analysis and linkage to related efforts;
- Identification of specific priority areas where this Task Force is best suited to contribute;
- Convening workgroups to begin to develop recommendations in these areas; and

- Advocacy on 2015 policy and budget legislation that will affect the continuum of care and the ITA system in particular over the long-term.

The Task Force and its many community partners have worked together to end psychiatric boarding in King County and maintain the gains achieved, with a view toward a system designed to intervene earlier, reduce demand, and deliver the right care to the right person at the right time.

Next Steps

As medium- and long-term system design work continues over the next year, the Task Force intends to prepare policy and legislative recommendations in several specific areas where it can have meaningful impact. Continued progress toward this goal will be reported to the Council on January 30, 2016, and final recommendations will be submitted by June 30, 2016.

The Community Alternatives to Boarding Task Force

Objective & Charter

In August 2014, Governor Jay Inslee and King County Executive Dow Constantine co-convened the Community Alternatives to Boarding Task Force. It's objective is to ensure that all King County residents experiencing mental health and/or substance abuse crises have access to prevention, intervention, and least restrictive treatment services as needed and to community alternatives as appropriate.

During its early meetings in fall 2014, the Task Force adopted a charter to guide its work over the next two years. Via the charter, members embraced a charge to develop solutions for individuals in mental health and substance abuse crisis focusing on prevention, intervention, and least restrictive alternatives. The Task Force committed to seeking solutions collaboratively for broad policy issues, solicit and generate creative ideas, and develop and share recommendations that may be implemented in King County and in other communities. Toward this end, the Task Force agreed to develop broad partnerships, create bigger and achievable goals, use and share better data, and take bold action that delivers results.

In order to achieve this objective, the Task Force will draft a Behavioral Health Strategic Plan with the following components:

1. Clear linkages between the work of the Task Force that furthers existing behavioral health work and endeavors, specifically integrated with the work of the Behavioral Health Integration Design Committee, launching in the summer of 2015

2. Recommendations for system improvements resulting in a continuum of care that:
    a. Serves consumers across all age ranges, including children and parents
    b. Reduces demand for involuntary detention
    c. Increases community alternatives to detention
    d. Prioritizes mechanisms that prevent behavioral health events from becoming crises
    e. Ensures appropriate treatment beds available, voluntary and involuntary
    f. Provides necessary resources to providers, including state and county services
    g. Builds on and leverages existing successes.

3. Proposed performance targets and oversight/reporting plans

4. Identified policy or legislative changes that support system improvements and drive toward a continuum of care.

The Task Force charter is included as Appendix B to this report.

Membership

The Task Force is comprised of representatives from:

- The state Division of Behavioral Health and Recovery (DBHR);
- Western State Hospital;
- The Washington State Hospital Association;

- Harborview Medical Center and Navos Psychiatric Hospital and Residential E&T;
- Department of Community and Human Services' Mental Health, Chemical Abuse and Dependency Services Division staff, including its Designated Mental Health Professional (DMHP) unit;
- Superior Court;
- Office of the Prosecuting Attorney; and
- Department of Public Defense.

A full list of Task Force members is included in Appendix C.

Task Force Guiding Principles

Task Force members also articulated nine guiding principles to shape and inform the work and recommendations of the group. Its solutions and recommendations will:

1. Be family and individually focused;
2. Be consumer-informed;
3. Be based in the principles of recovery and resiliency and reflect King County's behavioral health system's trauma-informed approach to services;
4. Be built upon shared ownership of the system and continuum by providers, consumers, and the county;
5. Leverage other resources whenever possible;
6. Align with opportunities under the Patient Protection and Affordable Care Act (ACA) and health reform;
7. Be equity and social justice oriented;
8. Be system-focused, emphasizing increased efficiencies and effectiveness; and
9. Integrate behavioral health and primary care when possible.

Task Force Approach

The Task Force is committed to collective problem solving. At inception, the Task Force was confronted with the urgent challenge to end and prevent boarding; in response, the team used collaborative problem-solving to jointly create solutions. Each team member came to the table with unique knowledge, expertise, and insight to share. The team has engaged in big picture system design work and short-term process improvements that have built trust and confidence, both within the Task Force and among stakeholders. The group has been effective in removing or resolving longstanding barriers to treatment access and system wide improvements through this collaborative approach to problem-solving.

With a goal of developing a more comprehensive behavioral health system approach for individuals in crisis, including preventive approaches that offer earlier diagnosis and intervention strategies and that reduce demand for ITA, the Task Force engaged in a process to identify potential areas for long-term change. The process involved innovative work to envision an improved crisis response system, including upstream intervention and prevention strategies, an environmental scan of opportunities and challenges, and a designation of priorities that will guide its forthcoming design efforts.

2015 Legislative Session

The convening of the Task Force in the fall of 2014 coincided with the development of the Governor's budget for the 2015-17 biennium. The Task Force identified urgent priority recommendations for the Governor's budget, and worked with the Governor's staff to submit recommendations for consideration. See the Legislative and Policy Changes section on page 40 for more detail about Task Force's input.

Background

Washington's Involuntary Treatment Act

Washington's Involuntary Treatment Act also known as the ITA, was originally implemented in 1973. It provides a legal basis for the civil detention and involuntary psychiatric treatment of individuals with significant risks arising from mental health disorders. The ITA seeks to balance due process and individual rights with access to treatment and community and individual safety. Over the years, the ITA has evolved and changed as lawmakers respond to crisis events and treatment access challenges. Many of these changes involve revisions to the grounds for commitment, including expanding the criteria.

The ITA provides for people who have mental health disorders that cause certain substantial and/or imminent risks to themselves, others, others' property, or grave disability to be detained and civilly committed to involuntary treatment for certain intervals: 72 hours, 14 days, 90 days, and 180 days with Court review at each interval.[2] The ITA law is found in Revised Code of Washington (RCW) chapters 71.05, covering adults, and 71.34, covering youth under age 18.

Investigation and Detention by Designated Mental Health Professionals (DMHPs)*:* While in most states physicians have the authority to detain people for involuntary psychiatric treatment, Washington's law limits this responsibility solely to trained professionals known as designated mental health professionals (DMHPs). When a referral to a DMHP is received from a provider or community member regarding a person who may be in need of an evaluation for potential involuntary mental health care, DMHPs screen and evaluate individuals in hospitals or community settings. Whenever appropriate, they conduct thorough investigations of the level of risk resulting from a person's mental disorder, according to specified legal standards. These investigations must include:

- In non-emergent situations, interviewing the person who has been referred for involuntary treatment;[3]
- Obtaining statements (also known as "declarations") from first-hand witnesses to the person's behavior;
- Considering the observations and opinions of examining emergency room physicians when applicable;[4] and
- Considering all reasonably available information from credible witnesses and records, including historical behavior, violent acts, history of a finding of incompetency to stand trial or previous civil commitments, as well as the perspectives of family members, landlords, neighbors, or others with significant contact and history of involvement with the person.[5]

Involuntary Detention Requirements*:* A person may be detained for involuntary inpatient psychiatric treatment in Washington State when either a likelihood of serious harm or grave disability are evident as a result of a mental disorder, when no appropriate less restrictive alternatives can be arranged to mitigate the risk, and when the person is not willing or able to accept treatment voluntarily.[6] One or more of the following conditions must be met:

[2] Revised Code of Washington (RCW) 71.05.150, 71.05.180, 71.05.230, and 71.05.280.
[3] RCW 71.05.150.
[4] RCW 71.05.154.
[5] RCW 71.05.212 and 71.34.212.
[6] RCW 71.05.020 and 71.34.020.

- A substantial risk that, as a result of a mental disorder, physical harm will be inflicted by a person upon himself or herself, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself or herself;
- A substantial risk that, as a result of a mental disorder, the person will inflict physical harm on another person, as evidenced by behavior which has caused such harm or which places others in reasonable fear of sustaining such harm;
- A substantial risk that, as a result of a mental disorder, the person will significantly damage the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others;
- As a result of a mental disorder, the person has threatened the physical safety of another person and has a history of one or more violent acts;
- As a result of a mental disorder, the person is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or
- As a result of a mental disorder, the person manifests severe deterioration in routine functioning, as evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions, and is not receiving care that is essential for his or her health or safety.

***Emergent vs. Non-Emergent Detention**:* In cases where imminent danger is evident, the law requires the DMHP to detain the person immediately and place him or her into an appropriately certified facility for a 72-hour evaluation and treatment period.[7] This is referred to as emergent detention and is done in order to ensure that hospitalization can proceed without delay to preserve safety. In such cases, Superior Court review occurs at the end of the initial 72-hour period to determine whether further involuntary treatment is warranted.

If the level of risk is substantial but not imminent, the DMHP petitions Superior Court for an order to detain the person under the non-emergent detention provisions of the ITA. A judge reviews the evidence gathered by the DMHP, and may or may not order involuntary inpatient treatment. If treatment is ordered, the DMHP places the person into an appropriately certified facility.[8] It is important to note that in King County judges make themselves available for these reviews around the clock and on a near real-time basis, allowing for expedient detention and access to care even in non-emergent cases. This level of judicial support is not in place statewide, which has limited the use of non-emergent detention in other communities.

***Commitment Periods**:* At the end of the 72-hour period, the staff of the facility where the person is placed may petition the Court for up to 14 days of commitment if further inpatient care is needed and the person is unwilling to consent to it voluntarily, or if certain other conditions are met.[9] Furthermore, if the person requires inpatient treatment beyond the 14-day order, the facility may petition the Court to commit the person for a longer-term inpatient treatment period of 90 days, and then successive 180 day petitions may be filed. For King County residents, Western State Hospital (WSH) is the only certified long term treatment facility available.

***Less Restrictive Alternative Treatment**:* The Court may order the person to 90 days of less restrictive treatment (or 180 days for a youth under age 18) instead of ordering involuntary inpatient treatment, at the end of the 72-hour period, 14-day period, or any subsequent 90- or 180-day period. This requires

[7] RCW 71.05.150 and 71.34.710.
[8] RCW 71.05.153.
[9] RCW 71.05.280.

that the person must participate in involuntary outpatient care with certain conditions often including a specific level of attendance at treatment activities and/or compliance with a medication regimen. If a person does not comply with these terms, and deteriorates to the point that they meet the detention criteria outlined above, their less restrictive order may be revoked and they may be returned to an involuntary inpatient care setting.

New legislation from the 2015 State Legislature (Engrossed Second Substitute House Bill 1450) will add a new category for less restrictive alternative treatment called assisted outpatient mental health treatment. This new category will allow courts to order involuntary treatment in an outpatient setting without an initial hospitalization, and will change and add new modification and revocation options that may be implemented by courts and providers for all less restrictive alternative orders, effective July 24, 2015. See Medium- and Longer-Term System Improvements on page 36 for further discussion of potential implications of this policy for the Task Force's work, as well as Appendix G for further details.

***Evaluation and Treatment Facilities**:* Washington State certifies certain programs, called evaluation and treatment (E&T), to provide short-term involuntary inpatient psychiatric treatment as required under the ITA whenever detention standards are met and less restrictive alternative treatment is not appropriate. E&T programs are designed to provide a treatment environment that is specifically suited to the needs of people who cannot maintain safety in the community and are in need of involuntary mental health care. Usually these beds are used for the 72-hour detention and 14-day commitment periods. Many voluntary psychiatric units in community hospitals do not hold this certification for involuntary E&T services.

In King County there are five facilities with certified E&T Programs:

- Fairfax Hospital in Kirkland, serving adolescents and adults;
- Harborview Medical Center in Seattle, serving adults,
- Navos in West Seattle, serving primarily adults;
- Northwest Hospital Geropsychiatric Center in Seattle, serving almost exclusively older adults; and
- Cascade Behavioral Health in Tukwila, serving adults, which is newly certified.

***Institutions for Mental Disease Rule**:* A Medicaid rule from 1965, meant to prevent states from shifting the costs of long-term institutionalization of people with chronic behavioral health conditions to Medicaid by moving people from state hospitals to large institutions, prohibits the use of Medicaid funds to reimburse care for adults with mental illness or drug and alcohol issues who are in behavioral health facilities with more than 16 beds. Facilities with more than 16 beds that are not part of larger medical centers are known as IMDs. For many years, this rule has forced Washington to use its scarce state funds to pay for care in its larger facilities, draining resources from crisis response systems and innovative community-based programs.

A key exclusion in the IMD Medicaid rule is that it does not apply to people older than 65 or younger than 21: individuals in these age categories who are in IMDs can be covered by Medicaid if they are eligible. Additionally, as described in more detail in the Critical Support from State and Federal Partners section on page 27 below, Washington has recently received temporary and limited waiver allowing Medicaid to be used to fund short-term acute mental health care in IMDs in lieu of more expensive hospital care, but the IMD rule still applies to mental health residential care as well as substance abuse services, including detoxification.

Psychiatric Boarding = Treatment Access Crisis

"Psychiatric boarding" or "boarding" became shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment – exceeded appropriate available resources. When appropriate treatment beds were not available, individuals were detained and waiting in less than optimal settings such as emergency departments (EDs) until a psychiatric bed became available. This has been a nationwide problem that had been affecting Washington and King County since at least 2009.

The Washington State Supreme Court, in its 2014 *In re the Detention of D.W. et al* decision, defined psychiatric boarding as temporarily placing involuntarily detained people in emergency rooms and acute care centers to avoid overcrowding certified facilities. In doing so, it emphasized the inappropriateness of the placement, and the chief reason for not providing inpatient psychiatric care at the right time – lack of capacity.[10] More information about this seminal Court decision appears in the Single-Bed Certification and the *D.W.* Supreme Court Ruling section on page 17 below.

The Task Force recognized psychiatric boarding as a major treatment access crisis that hurts patients and drives resources away from community-based and preventive care. Nationally, studies show that prolonged waits in emergency departments for psychiatric patients are associated with lower quality mental health care, as the chaotic ED environment increases stress and can worsen patients' conditions[11] and due to the tact that adequate psychiatric services are often not provided.[12]

The overarching purpose of the Task Force is to bring together system changes at all levels to eliminate psychiatric boarding in King County in a sustainable way.

The Impact of Declining Resources – Psychiatric Care in Hospital Emergency Rooms: More and more people are seeking psychiatric care via hospital EDs – in 2007, 12.5 percent of adult ED visits were mental health-related, as compared to 5.4 percent just seven years earlier. Of psychiatric ED visits, 41 percent result in a hospital admission, over two and a half times the rate of ED visits for other conditions,[13] and between 2001 and 2006 the average duration of such visits was 42 percent longer than for non-psychiatric issues.[14] The growth in these figures may result from the difficulty people experience in accessing community mental health services *before* they are in crisis, as well as the dramatic reduction in inpatient psychiatric capacity nationally, that began as part of deinstitutionalization in the 1960s and has continued until very recently.[15]

In King County and Washington, this phenomenon has been driven by a confluence of factors: community and inpatient resources are scarce, while at the same time the treatment need is very high,

[10] *In re the Detention of D.W., et al.* Case 90110-4. Washington State Supreme Court, retrieved from http://www.courts.wa.gov/opinions/pdf/901104.pdf.

[11] Bender, D., Pande, N., Ludwig, M. (2008). *A Literature Review: Psychiatric Boarding: Office of Disability, Aging and Long-Term Care Policy*. Retrieved from http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf.

[12] American College of Emergency Physicians. ACEP Psychiatric and Substance Abuse Survey (2008), as cited in Abid, Z., Meltzer, A., Lazar, D., Pines, J. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[13] Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: Agency for Healthcare Research and Quality (2010), as cited in Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[14] Slade EP, Dixon LB, Semmel S. Trends in the duration of emergency department visits, 2001-2006. *Psychiatr Serv* 2010, 61(9), 878-84, as cited in Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

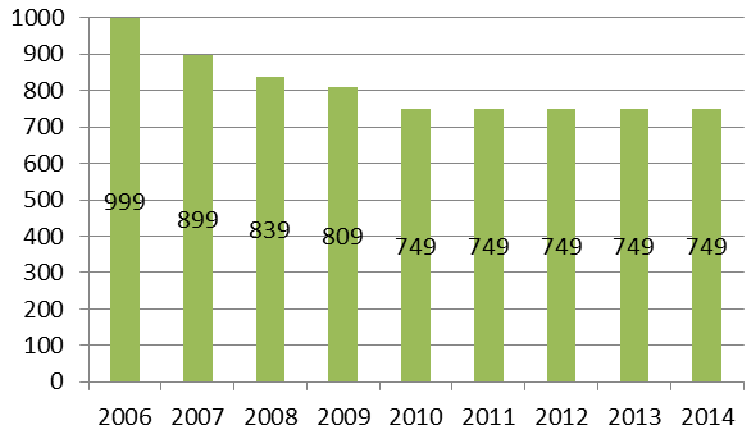
[15] Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

the population is growing quickly, and laws are changing increasing the likelihood of involuntary detention.

Resource Scarcity: The escalation of boarding in our community in recent years has coincided with significant reductions in a variety of critical treatment resources.

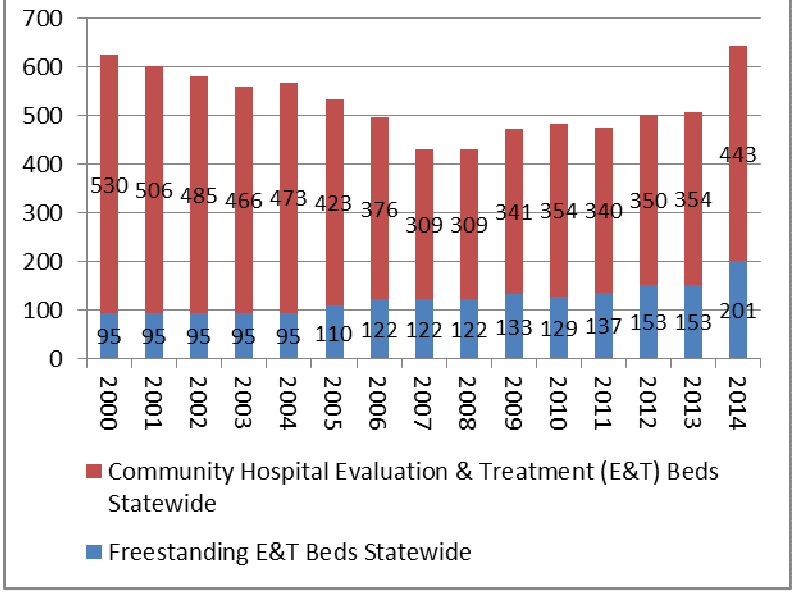
As shown in Exhibit 1, the number of available civil state hospital beds where patients committed under the ITA receive long-term treatment if needed, dropped 25 percent (a loss of 250 beds) between 2006 and 2011. They remain at these historically low levels.[16]

Exhibit 1
Adult Civil Commitment Bed Capacity in Washington's Two State Hospitals, 2006-2014



Furthermore, as depicted in Exhibit 2, the number of community hospital and E&T facility beds in Washington certified for involuntary patients also fell by 31 percent (a loss of 194 beds) between 2000 and 2007, as many independent community hospitals closed their certified psychiatric units or reduced the number of available beds. Seventy-six of those beds were gradually restored over the next few years, but this still left a net reduction of 118 beds (19 percent) as recently as 2013.[17]

Exhibit 2
Washington Community Inpatient Psychiatric Beds Certified for Involuntary Adult Patients 2000-2014



2014 brought a major increase of 159 involuntary inpatient beds statewide, as the state and local communities have begun to add new resources to address the crisis, which has brought the total number of beds statewide back to approximately the same levels as in 2000.[18] Also, both chambers of the

[16] Legislative Evaluation and Accountability Program Committee. Operating Budgets for fiscal years 2007-14, Mental Health Program sections, retrieved from http://leap.leg.wa.gov/leap/budget/index_lbns.asp.
[17] Burley, M., & Scott, A. (2015). *Inpatient psychiatric capacity and utilization in Washington State* (Document Number 15-01-54102). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf.
[18] Burley, M. & Scott, A. (2015).

legislature have proposed to add back one ward of 30 civil commitment beds to Western State Hospital. Although a welcome addition, this would still leave the hospital well below historical capacity levels.[19]

The dramatic reduction in inpatient resources during the mid-2000s contributed to Washington's overall ranking of 46th among states in per capita short-term mental health facility capacity (including both community hospital beds and E&T beds), according to a 2015 analysis by the Washington State Institute for Public Policy (WSIPP) of data from Substance Abuse and Mental Health Services Administration's (SAMHSA) 2010 National Mental Health Services Survey (N-MHSS).[20]

Major cuts to flexible non-Medicaid mental health funds from the state have also significantly affected treatment access. These non-Medicaid funds are prioritized for crisis, involuntary commitment, residential, and inpatient services and play an important role in creating and maintaining a comprehensive continuum of community-based care. They also enable King County to facilitate treatment access for individuals who do not have Medicaid. As shown in Exhibit 3, between state fiscal years 2009 and 2015, there was a loss of $33.2 million (27 percent) statewide for these critical services. Consequently, the reductions have had deep and dramatic effects on the community's ability to respond to growing need and maintain or develop creative crisis solutions to reduce involuntary treatment demand.

Exhibit 3

State Flexible Non-Medicaid Mental Health Funding Reduced 27% between Fiscal Years (FY) 2009 and 2015

This severe resource scarcity has coexisted with a very high prevalence of treatment need in Washington as compared to other states. Analysis of data from the federal SAMHSA 2010-11 Mental Health Surveillance Survey (MHSS) found that Washington ranked in the top three among states in the prevalence of any mental illness (24 percent of the population) and serious mental illness that substantially affected one or more major categories of functioning (seven percent).[21]

ITA Law Changes: Meanwhile, many ITA policy changes have been implemented in recent years, most of them designed to make it easier to detain people in crisis involuntarily and/or to extend inpatient stays

[19] Legislative Evaluation and Accountability Program Committee. Operating Budget Proposals 2015-17, Mental Health Program section 204, retrieved from http://leap.leg.wa.gov/leap/budget/detail/2015/ho1517p.asp and http://leap.leg.wa.gov/leap/budget/detail/2015/so1517p.asp.
[20] Burley, M. & Scott, A. (2015).
[21] Burley, M. & Scott, A. (2015).

for these individuals. For example, according to a WSIPP survey from 2011, just one of these changes, which required a more wide-ranging investigation from a broader range of sources beginning in mid-2014, may on its own increase the statewide detention rate by nearly one-third, creating a need for up to 168 additional psychiatric beds.[22]

Still more expansions of the grounds and processes under which a person may be detained under the ITA passed during the 2015 legislative session, including authorizing family members to seek direct judicial review of DMHP decisions not to file an ITA petition (see discussion of Joel's Law below), and commitment to involuntary outpatient treatment. These will all provide additional opportunities for people to receive involuntary care. However, they will also impact already scarce inpatient capacity and increase the caseload of King County's ITA Court along with the attorneys, staff, and judicial officers who work in that court. The degree of those impacts and the increase in caseload is unknown at this time. (More details about these and other new policies are included in Appendix G.)

One law in particular from the 2015 session is expected to have a major, though as yet unquantifiable, impact on the ITA system and process. Joel's Law (Engrossed Second Substitute Senate Bill 5269), allows an immediate family member, guardian, or conservator of the person to petition the Superior Court for the person's initial detention in two situations: (1) if the DMHP fails to take action to have the person detained within 48 hours from receipt of a request for investigation; and (2) the DMHP decides not to detain the person. The court has one judicial day to review the petition to determine whether it raises sufficient evidence to support the allegation. If the court so finds, it provides a copy of the petition to the DMHP agency and orders the agency to provide the court within one judicial day a written sworn statement describing the basis for the decision not to seek initial detention and a copy of all information material to that decision. The court then has five judicial days to enter an order either for: (1) initial detention upon a finding of probable cause to support a petition for detention and the person refused or failed to accept appropriate evaluation and treatment voluntarily; or (2) dismissal of the petition. If the court orders initial detention, the matter proceeds as if the court entered the order pursuant to RCW 71.05.150. If at any time the DMHP decides to file a petition for initial detention under RCW 71.05.150 or 71.05.153, the court will dismiss the petition filed under Joel's Law.

Population Growth: All the while, the population of King County grew by an estimated 20 percent between 2000 and 2014 – almost 343,000 people. Meanwhile, the state's population increased by approximately 20 percent as well – or nearly 1.2 million.[23] Even just this one factor alone – the addition of so many additional residents – would have placed more pressure on an overstretched inpatient treatment system.

King County ITA Court Caseload Growth

Due to the factors described above, the caseload for King County's ITA Court has increased dramatically between 2006 and 2014 – filings jumped by 1,627 cases, or 73 percent, over eight years, as shown in Exhibit 4 on the next page.[24]

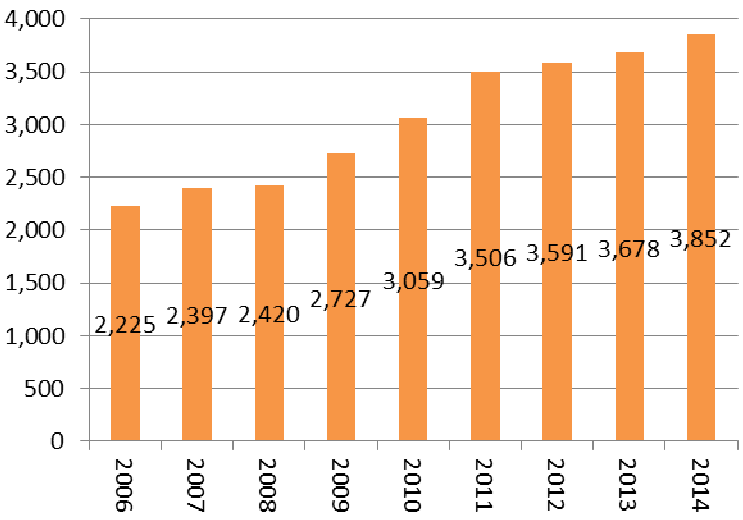
[22] Burley, M. (2011). *How will 2010 changes to Washington's Involuntary Treatment Act impact inpatient treatment capacity?* (Document No. 11-07-3401). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1092/Wsipp_Inpatient-Psychiatric-Capacity-in-Washington-State-Assessing-Future-Needs-and-Impacts-Part-One_Full-Report.pdf.

[23] U.S. Census Bureau State and County QuickFacts, retrieved from http://quickfacts.census.gov/qfd/states/53/53033.html, and Population for the 15 Largest Counties and Incorporated Places in Washington: 1990 and 2000, retrieved from https://www.census.gov/census2000/pdf/wa_tab_6.PDF.

[24] King County ITA Court data.

The growth translates to increased demands for staff, judicial officers, space and other needs. The costs of ITA Court are paid using scarce non-Medicaid mental health funding, and directly impact resources available for DMHP to conduct the ITA evaluation and for treatment services. Despite the positive system impacts that the work of the Task Force is having, the upward trend is expected to continue with ITA caseloads likely to grow at a faster rate with the passage of Joel's Law.

Exhibit 4
Dramatic Increase in King County ITA Court Filings 2006-2014



ITA caseload growth has created additional stress on clients and their families, who may have to wait hours for their Court hearings – a wait which takes clients out of the treatment setting to which they have been detained and impacts their confidence in the Court. Prosecution and defense attorneys' efforts to negotiate less restrictive alternative arrangements, voluntary treatment agreements, or other mutually workable solutions have been curtailed by a Court calendar that is compressed by demand and scarce community resources available for treatment. These added pressures, coupled with the tensions they create, can undermine cooperation at the individual case disposition level, even when all parties desire to work together for the benefit of clients.

Superior Court has been so challenged to meet capacity that a small second courtroom was built in 2013 out of half of a public waiting room in the ITA Court. The "chambers" for the judicial officer who presides in that second court was built out of a closet. The issue of space is a continuing concern for all parties, with the Court, Council, and Executive seeking space solutions to address the growing demand for Court services.[25] On June 1, 2015, the King County Council unanimously passed a motion asking the County Executive to provide the Council by August 17, 2015 with a report describing options and strategies to alleviate crowding and other space limitations for the ITA Court.

Evaluation and Treatment Facility Capacity

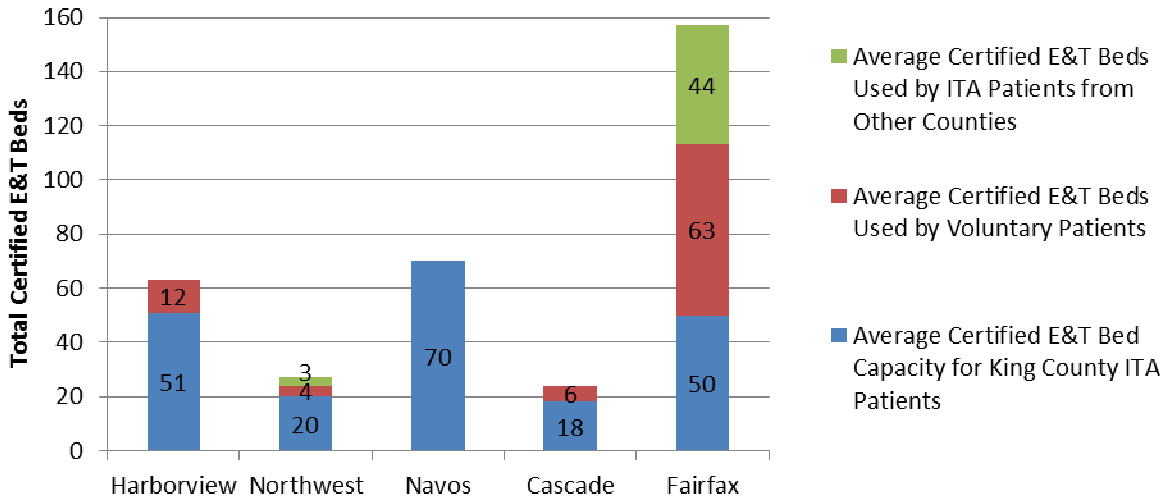
E&T facilities, some of which operate within larger medical centers, are administered by independent organizations, E&T facilities, some of which operate within larger medical centers, are administered by independent organizations, not by the regional support networks (RSNs). Some beds that are certified for involuntary treatment are occupied by voluntary patients who have not been committed under the ITA, and/or in some cases, by patients from other counties. Hospital-based beds and freestanding E&Ts other than Navos are treated as a regional resource accessible across county lines. Furthermore, all five King County E&T facilities have operated at or near capacity on a daily basis for several years.

[25] King County Superior Court 2013 Annual Report.

Due to these competing factors, on average only 209 out of the 341 certified E&T beds in King County (61 percent) are actually occupied by King County ITA patients, with 85 beds serving voluntary patients and 47 used by ITA patients from other counties.[26]

As shown in Exhibit 5 below, there is a great deal of variation in the degree to which different E&T facilities located in King County make space for various categories of patients. For example, data shows that Fairfax's very large facility serves only the third-most King County ITA patients, compared to Navos, with half the bed capacity, serving the most ITA patients. Harborview Medical Center almost exclusively serves people detained in King County and serves a modest number of voluntary patients.

Exhibit 5
39% of E&T Beds in King County Occupied by Out-of-County or Voluntary Patients
Daily averages by facility, spring 2015



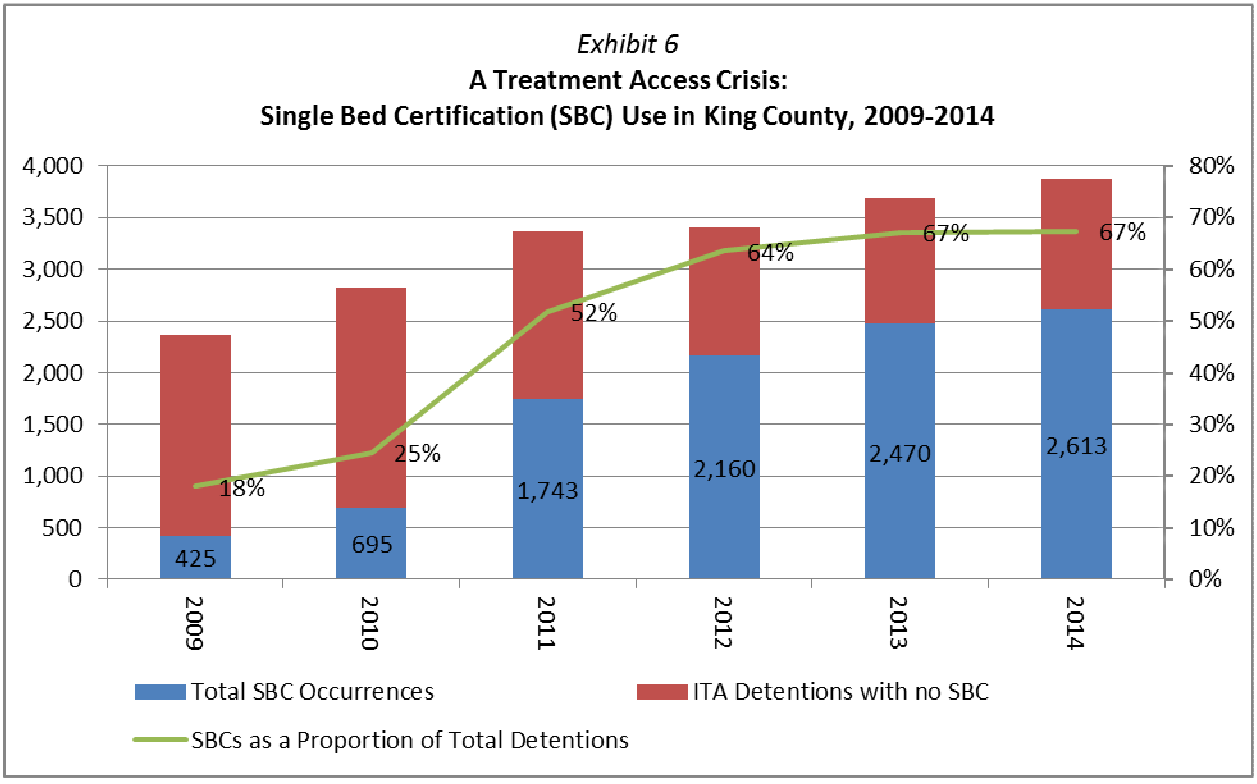
Single Bed Certification and the *D.W.* Supreme Court Ruling

Single Bed Certification 2009-14 – Safe but Insufficient Treatment: In 2009, in response to the already-escalating involuntary treatment capacity problem in Washington, a new section 388-865-0526 was added to the Washington Administrative Code (WAC) to institute a single bed certification (SBC) process. This protocol was added to provide temporary certification that allowed individual patients detained under the state's Involuntary Treatment Act to be served in non-E&T hospital settings such as medical units, voluntary psychiatric units, or when necessary, emergency departments. Psychiatric care appropriate to an involuntary patient was often lacking in these settings, with patients sometimes left strapped to gurneys in hallways without being seen often enough by mental health professionals or psychiatrists, or otherwise insufficiently treated for unacceptable periods of time.

Though this provision kept people in behavioral health crisis safe when E&T beds were not available, it also became a mechanism by which far too many people were held in settings that did not adequately meet their behavioral health care needs. The initial rule creating SBCs did not articulate any specific requirements for the person's care, making the patient's experience quite variable depending on individual hospitals' capacity and practices.

[26] King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) surveys of evaluation and treatment (E&T) facilities, March 2015 and May 2015.

Escalation in King County SBC Use: Prior to the Court's August 2014 ruling, the use of SBCs had been escalating for several years – a sign of the treatment access crisis affecting thousands of residents with acute care needs. In King County, for example, the number of involuntarily detained individuals who did not receive direct access to an E&T facility had been growing at an alarming rate, from less than one-fifth of all detentions in 2009 to two-thirds in 2013 and 2014, as shown in Exhibit 6 below.



In just over four years, when the capacity crisis escalated in 2011 until the end of 2014, there were 8,986 instances of SBC use in King County alone.[27]

A Mandate for Urgent Change: *In re the Detention of D.W. et al*: On August 7, 2014, the Washington State Supreme Court's ruling in *In re the Detention of D.W. et al* prohibited holding psychiatric patients on SBCs in non-psychiatric settings solely due to lack of inpatient capacity at certified E&T facilities. The Court found that funding limitations or capacity shortages in certified E&T facilities are invalid reasons for detaining a person while delaying the provision of appropriate mental health care.[28] King County and its community partners strongly supported this ruling because it directly addressed an enduring problem and made appropriate treatment access a primary priority throughout the state, creating an environment in which creative changes could occur. This ruling went into effect December 26, 2014, and is included with this report as Appendix D.

New SBC Requirements for Timely and Appropriate Care: Since the effective date of the Supreme Court ruling on December 26, 2014, SBCs may now only be used to hold a person involuntarily when the hospital is willing and able to provide timely and appropriate mental health treatment to the person. At

[27] King County MHCADSD database and reports.
[28] *In re the Detention of D.W., et al.* Case 90110-4. Washington State Supreme Court.

that time, the WAC governing SBCs was revised via an emergency rule in order to ensure that proper mental health care is being provided whenever an SBC is issued. As a result, instead of being a routine method to hold people with or without treatment while awaiting an E&T bed, SBCs now depend on the voluntary participation of a community hospital or other appropriate facility. Therefore, SBC use has varied throughout the state since the ruling due to the fact that approximately 60 percent of the 99 hospitals in the state are not willing or able to accept patients under the new conditions required for an SBC.[29] As described in the "Partnering with Community Hospitals" section on page 35, King County hospitals have been much more receptive than most in the state to the added responsibility that comes with SBC requests since the *D.W.* ruling.

There is broad agreement among all task force members that even the legally allowable use of SBCs to provide "timely and appropriate treatment" to people in crisis is a temporary stopgap, neither a preferred nor a long-term system solution. Our community and our state have an enduring capacity problem – and an urgent legal mandate – that require innovative and collaborative responses.

Environmental Analysis

Within this environmental context, the Task Force identified a range of favorable and unfavorable factors affecting its work, including local context as well as issues with statewide or nationwide origins:

	Enablers (Favorable Factors)	Challenges (Unfavorable Factors)
Factors Specific to King County	• Very strong leadership and collaborative culture in King County • Transformational wellness and health system work underway • Proactive agencies • Strong sense of partnership and commitment among players	• Funding/budget limitations • Entrenchment inherent in existing system • Many concurrent initiatives makes alignment and coordination challenging • Bias against King County • Shortage of DMHPs and attorneys
Statewide and Federal Factors	• Recent State Supreme Court ruling on boarding • Increased legislative interest in mental health, creating opportunity to influence policy in Olympia • History of community-based funding and programs • Health care and behavioral health reform • Increased perceived value and recognition of mental health • Strong partners and leadership by the Governor, state agencies and public sector organizations	• Unintended consequences of state legislative and funding decisions, including sustainability of existing programs, allocation of resources, and need for new dollars • Current state revenue structure • Institution for Mental Diseases (IMD) rule prohibiting use of Medicaid to pay for residential and detoxification services in facilities larger than 16 beds • Financial focus and structure of managed care organizations (MCOs)

[29] Estimates provided by Washington State Hospital Association (WSHA) in May 2015.

In addition to the factors identified by members, several other related policies and decisions have been recognized as part of the landscape that is promoting broad engagement with the creative system change that is needed to address a community treatment access crisis.

2SSB 6312, ESHB 1519, 2SSB 5732, and Behavioral Health/Primary Care Integration: The 2014 state legislature passed a landmark behavioral health integration bill, Second Substitute Senate Bill 6312 that is having wide-ranging impact on the publicly funded mental health and substance abuse treatment system by requiring clinical and financial integration to break down siloed funding and services. 2SSB 6312 specifically mandated the integration of mental health and substance abuse purchasing by April 1, 2016, and has led to intensive and accelerated planning for the transition of the fee-for-service substance abuse treatment system into a single managed care system along with mental health, coordinated by nine local behavioral health organization (BHOs). The BHO structure will replace the current RSN and county chemical dependency coordinators system and provide integrated mental health and substance use disorder treatment services through a single integrated managed care contract. Further, the bill mandates integration of behavioral health care with primary care by 2020. Partner bills from the 2013 legislature, Engrossed Substitute House Bill 1519 and Second Substitute Senate Bill 5732, mandate the development of cross-system performance measures for health plan contracting and system monitoring.

King County strongly supports the three main goals of these pieces of legislation – clinical and financial integration of behavioral health care, meaningful integration with primary care, and robust performance measurement and evaluation. The County is working closely with its provider and state partners to identify and implement the best care and financial model for our community. More specific information about King County's work in this area is included in the "Behavioral Health Integration" update on page 39.

Medicaid Expansion via the Affordable Care Act*:* The Patient Protection and Affordable Care Act of 2010 (ACA) broadened health care coverage to millions of Americans via health benefit exchanges and (in many states) expansion of Medicaid coverage to low-income individuals. This allowed individual to access healthcare based solely on their financial circumstances and no longer required concurrent documentation of a disability. King County led a campaign in 2013-14 that enrolled 140,000 previously uninsured individuals into Medicaid as part of the County's concerted effort to lead implementation of the ACA, via a partnership involving Public Health, DCHS, and many community partners. Upon implementation of expanded Medicaid in 2014, this dramatic extension of the health care safety net has created increased demand for publicly funded behavioral health care and challenged mental health and substance abuse providers to respond to clients with different needs.

Mental Illness and Drug Dependency (MIDD) Sales Tax and Renewal Efforts*:* King County's Mental Illness and Drug Dependency (MIDD) one tenth of one percent sales tax, approved by the County Council in 2007 expires at the end of 2016 unless renewed. The MIDD is a unique local resource that is helping to shape and make possible the kinds of creative and preventive solutions that are needed to create a full continuum of care. Although primary responsibility for funding behavioral health care lies with the state and federal jurisdictions, MIDD remains a robust local fund source for flexible upstream solutions that fit with our local community's goals. As such, it is currently undergoing a systematic review and design process under the direction of its oversight committee, in preparation for potential renewal by the Council in 2016.

Competency Evaluation Timeliness and the Trueblood Ruling: Individuals who may be incompetent to stand trial must be evaluated for competency before criminal proceedings can proceed. If found incompetent – unable to understand the charges against them and unable to assist in their own defense – these individuals must undergo a renewable period of competency restoration treatment, most often at a state hospital.[30] Once deemed competent, they are returned to the originating Court for trial. However, if competency cannot be restored, these individuals are often converted to civil commitment status under the ITA statute described above, resulting in further treatment that affects state hospital and community hospital capacity for non-forensic patients, as well as ITA Court caseloads.

Severe delays in competency evaluation by the state have left clients languishing in jails rather than proceeding to restoration treatment or trial, raising civil rights concerns. This resulted in a federal class-action lawsuit on behalf of affected individuals, referred to as the *Trueblood* lawsuit. On April 2, 2015, Chief U.S. District Court Judge Marsha Pechman ruled that in order to respect the civil rights of people whose competency is in question, all competency evaluations must be completed within seven days.[31] Even as the state considers its appeal options, significant cross-system work is under way in King County and statewide to improve coordination and begin to deliver competency evaluation in accordance with the ruling.

In light of these major motivators of change, a wide variety of processes were already either under way or being initiated as the Task Force began its system design efforts in earnest. In accordance with its charter, the Task Force resolved to coordinate actively with these other efforts.

Existing Initiatives

The Task Force identified and discussed linkages to allied or related work and groups with which members either had direct involvement or significant knowledge and access. Specific Task Force members were identified as connectors to each initiative, with a responsibility to serve as information conduits to bring the Task Force's work and recommendations to those groups, and to keep other Task Force members updated about any significant developments or opportunities that may be arising in those venues. The Task Force is committed to working in partnership and coordination with others undertaking related efforts.

Linked initiatives identified via this process are described in the table below and on the next page.

Existing Initiative	Primary Focus
Accountable Communities of Health (ACH)	Health Care Authority (HCA) initiative to improve how services are purchased, to ensure health care focuses on the whole person, and to build healthier communities through a broad, collaborative, regional approach, with a strong data collection and evaluation component
Adult Behavioral Health Task Force	Responsible to make recommendations for reform concerning the means by which behavioral health services are purchased and delivered, including development of key outcome measures

[30] RCW 10.77

[31] *Trueblood v. WA State Dept. of Social and Health Serv.* Case C14-1178 MJP. U.S. District Court, Western District of Washington at Seattle, retrieved from http://www.disabilityrightswa.org/sites/default/files/uploads/AB%20Jail%20Delay%20Court%20Order.pdf.

Existing Initiative	Primary Focus
Association of County Human Services	RSN managers and substance abuse coordinators representing each county, identifying areas of shared concern and advocacy
Behavioral Health Integration	Statewide effort to improve outcomes through the integration of mental health, substance abuse and primary care
Best Starts for Kids / Youth Action Plan	Prevention-oriented levy and planning to boost King County's investments in children and work to eliminate inequities
Center City	Focused on improved public safety in downtown Seattle and effectively addressing needs of people in crisis who live there
Children and Family Justice Center Planning	Development of this new facility intersects with mental health services and juvenile drug Court
Committee to End Homelessness	Collaborative work to create the housing and supportive services needed to reduce and end homelessness, in place since 2005
Communities of Opportunity	Launched by the Seattle Foundation and King County to improve health, social, racial and economic outcomes by focusing on specific communities
County Re-Entry	Multi-agency work group coordinates planning and implementation of evidence-based practices addressing risks and needs of individuals caught in the revolving door of recidivism and disenfranchisement
Criminal Justice Council	Separately elected justice agencies' executive council, stemming from the 1999 master plan
Familiar Faces	Systems coordination and redesign for individuals who are frequently booked into jail, the vast majority of whom also have a mental health and/or substance condition
Long-Term Care Group	Identifies appropriate community-based placements for individuals in the long-term care system, to assure mental health resources at state institutions are used for those who benefit from psychiatric treatment
Mental Illness and Drug Dependency (MIDD) Sales Tax	Local sales tax to fund new and expanded mental health and substance abuse services, headed by a community oversight committee
Seattle Police Department (SPD) and Crisis Intervention Work	Includes SPD's crisis intervention team, related training, and co-location of mental health services with SPD
Speaker's Task Force	Makes recommendations to the House Speaker about improvements needed in the behavioral health system, including ITA, IMD, non-Medicaid funding, capital funding, link to schools, children's mental health and workforce development
Veterans/Human Services Levy	Generates funding to help veterans, military personnel and their families, and other individuals and families in need across the county through a variety of housing and supportive services

Connector communication between the Task Force and these other initiatives ranged from organizational updates describing the venues from which relevant recommendations can be expected, to specific policy or program design recommendations. The degree and nature of the intersection with the Task Force varied depending on the initiative. In some cases – such as the many groups directly taking on aspects of system design for behavioral health and health care integration – the improvements, innovations, and recommendations of the Task Force are often being shared organically as they develop in order to intersect with the timing of other change work. In other cases, where the allied group may be working on behavioral health as an aspect of a broader charge such as homelessness or public safety, the Task Force's work may be shared intermittently as the context dictates. Examples are shown below.

Recommendations Transmitted by Task Force Connectors to Related Groups

- Get youth and their families the mental health support they need to avoid the crises and behaviors that lead to justice system involvement.
- Provide seamless continuity of care (including medication and case management supports) through the cycle of arrest, detention, and release with the goal of supporting stability and avoiding crisis.
- Explore alternative procedures for persons in mental health crisis who are referred to ITA Court or who do not meet the ITA commitment standard but still require intervention over their current objection.
- Coordinate homeless and housing services for individuals and families to avoid crises and avoid criminal justice or emergency medical system involvement.
- Reduce the unnecessary use of expensive public services by filling in gaps to respond to community needs. Contribute funds to create a continuum of mental health treatment that is available to the community.

Relevant Developments or Recommendations from Related Groups

- Behavioral Health Integration: This work will be a subcommittee of the ACH. Clinical outcomes from behavioral health integration efforts at Harborview and other UW Medicine hospitals demonstrate significant improvement in depression and anxiety.
- Best Starts for Kids: This initiative includes behavioral health prevention strategies that will be relevant to the Task Force's target population.
- Children and Family Justice Center: CFJC will have space to support therapeutic, trauma-informed programs for youth and families.
- Committee to End Homelessness: Forthcoming plan supports a continuum of services to make homelessness rare, brief, and one-time.
- County Re-entry: Coordinate interventions to address both criminogenic and health needs of people returning from incarceration, using evidence-based practices.
- Criminal Justice Council: Develop the supports necessary to keep people from needing involuntary treatment in the first place, and provide sufficient resources for ITA Court.
- Familiar Faces (FF): Create person-centric, rather than program-centric, suite of supports and a case management team that includes health, housing, and legal providers. Identify one member of that team as the "golden thread" to establish a relationship and keep the person engaged. FF is a subcommittee of the ACH.
- Veterans and Human Services Levy: Service improvement plan addresses services for individuals with mental health needs in community health centers; older adults with mild depression in their homes; and new mothers experiencing post-partum depression.

Task Force Visioning for the Future

With this backdrop, the Task Force engaged in an open-ended envisioning process in October 2014, shortly after its convening, to capture members' ideas about the elements of an ideal system that encompassed appropriate prevention, early intervention, and least restrictive alternatives for people in behavioral health crisis. Members proposed and discussed a range of potential new resources and policy changes that would directly or indirectly reduce the demand for inpatient care and on the involuntary treatment system including DMHPs and the ITA Court.

Three categories were established as priority areas for action/further development in organizing the work:

- Prevention and intervention/care model
- Crisis services
- Legislative action.

These categories were further prioritized based on the time horizon for implementation: near-, medium-, and long-term. Factors considered when determining the time to implement included: 1) access to existing resources to support improvements or modifications; 2) whether new or additional funding resources within existing law and policy would need to occur; and 3) whether major policy changes were needed along with significant advocacy or new resources.

This initial visioning exercise and subsequent conversations served to generate a large number of ideas and set a tone of inclusion, openness and innovation. The conversation focused on new approaches and interventions across the continuum of care. Members were encouraged to "think outside the box" without the typical constraints of existing structures, siloes, requirements, or funding.

Priority Area Identification and Work Groups

Building on its fall 2014 visioning efforts, the Task Force deliberately considered what system design work it was best suited to undertake in light of the other initiatives and change processes already under way. The group considered such questions as which gaps need to be addressed to achieve its vision; what important work is not being addressed directly by other groups; and what work the Task Force is particularly well positioned to do.

The Task Force agreed on five priority areas to guide its work. These are described on the following page in no particular order.

Priority Area or Issue	Task Force Plan and Intent
1. Diversion and front-end/upstream re-engineering	To include: • Police diversion and training; • Patient outreach and engagement; • Real-time crisis respite; • Decreasing demand for involuntary treatment services via alternative approaches; • Criminal justice system diversion; and/or • Improvements to competency restoration processes.
2. Alternative processes and resources for patients with dementia, developmental disabilities, and traumatic brain injury	To include consideration of: • Appropriate legal processes and crisis responses; and/or • Appropriate and sufficient treatment resources.
3. Workforce support and development	To promote the development of a sufficient pool of qualified staff to: • Meet treatment demand; and/or • Implement innovative strategies.
4. Behavioral health integration	To include: • Linkage between RSNs/BHOs such as King County and MCOs, namely the state's five Apple Health plans; and/or • Active engagement to ensure alignment of activities.
5. Legislation and policy changes	To support coordinated advocacy by: • Tracking and sharing information about legislation as it develops; and • Identifying effects of legislation on King County.

In early spring 2015, subgroups were formed to begin designing systems and collaborative processes in each of the five priorities that had been identified for action.[32] The Medium- and Longer-Term System Improvements section beginning on page 36 outlines the work of these groups to date.

[32] Task Force members also planned to include youth screening and prevention as an upstream/preventative strategy across all five priority areas, as applicable. Recommendations related to this theme are under discussion by Task Force workgroups.

King County's Response to the Psychiatric Boarding Crisis

In early 2014 before the Court's ruling, the King County Department of Community and Human Services (DCHS), in partnership with the County Executive and the County Council, announced ending psychiatric boarding as a major priority. The County committed to working creatively with its partners to leverage existing resources while also seeking new avenues of funding whenever possible, in an effort to reduce demand and provide appropriate treatment. The following outlines the County's actions to date.

New, Expanded, and Repurposed Community-Based Programs

New community-based programs were implemented, while others were expanded or otherwise changed, to impact the boarding crisis specifically. Some of these initiatives were possible thanks to grants and targeted funding from the state.

- The Transition Support Program (TSP) is helping to speed discharge and ensure linkage between hospitalized individuals and community providers.
- The Peer Bridger program assists clients with the transition from hospital to community and to help implement discharge plans after release.
- Previously reduced funding for Next Day Appointments (NDAs) was restored, making it easier for people in crisis to access urgent care without seeking hospitalization.
- The Mobile Crisis Team (MCT) doubled in size and expanded its role to provide faster access to crisis support and community resources including the Crisis Solutions Center, in order to reach people before they require involuntary commitment.
- An improved system for utilization management of inpatient hospitalizations was implemented, designed to lead to in shorter lengths of stay for many patients.

New Inpatient Resources

Additional E&T resources have been brought online by King County and community partners to increase and improve access to inpatient care. Also, plans to add further resources are also under way at the time of the writing of this report.

With the opening of Cascade Behavioral Health in Tukwila in early 2015, 24 new E&T beds were added to the system. Fairfax Hospital, Navos, and Harborview Medical Center each made available additional involuntary psychiatric beds, during late 2014 and early 2015.

Planning for Additional E&T Facilities

Plans are underway to launch two new Medicaid-eligible E&T facilities in South King County. Valley Cities Counseling and Consultation (VCCC) and Telecare have been identified as operators for these sites, and King County is seeking additional resources to meet the capital and operating needs of the facilities. VCCC's Woodmont Recovery Center site will be designed as a comprehensive behavioral health campus. These facilities are planning to offer between 16 and 24 inpatient psychiatric beds each, starting in 2016.

Conversion of Hospital Space for Psychiatric Care

King County is partnering with the Washington State Hospital Association (WSHA) for development of involuntary medical psychiatric beds in existing community hospitals, including advocating for capital

funding for such projects. One such unit is planned at Providence-Swedish Ballard in Seattle, designed to assist individuals with co-occurring psychiatric and medical needs. The unit is expected to have a capacity of 22 beds once it is completed in mid-2016.

Critical Support from State and Federal Partners

Many of the innovations and coordinated actions above would not have been possible without critical funding and policy decisions from state and federal partners who were coordinating actively with King County's work to address boarding, including those listed below.

- **Emergency State Funding for Inpatient Expenditures:** In response to the Supreme Court ruling, the Governor authorized $30 million statewide in emergency state funding to support increases in inpatient expenditures resulting from expanded capacity developed to ensure access to acute care throughout the state. This influx of resources supplemented previous targeted funding that helped to launch some of the community-based initiatives described above.

- **Medicaid Waiver Authority:** The October 2014 renewal of the state's mental health managed care waiver with the Centers for Medicare and Medicaid Services (CMS) granted the state new authority to use Medicaid funds to pay for short-term stays in facilities larger than 16 beds – known as Institutions for Mental Disease (IMD) – when those services are provided in lieu of more costly hospital services. This waiver allows costly psychiatric inpatient stays in IMD facilities to be covered by Medicaid, potentially freeing up limited non-Medicaid funds for other essential or innovative services that may in turn reduce the need for hospitalizations. Early estimates suggest that King County may save approximately $2.9 million per year as a result of the waiver authority, which so far has helped to delay or avert cuts to state-funded community-based crisis and diversion programs that otherwise may have been curtailed due to the recent reductions in state flexible non-Medicaid funding. It is important to note that the waiver does not represent a complete or permanent solution, however, because it applies only to short-term acute-care mental health services and is subject to biennial renewal. Also, ongoing state funding is still needed to ensure treatment access for undocumented individuals and others who are ineligible for Medicaid, and for previously-eligible Medicaid participants for whom sizeable matching state funds are required.

Improved Outcomes: Immediate

Even as the Task Force's work toward system design recommendations was under way, its early focus during fall 2014 was on identifying efficiencies and improvements that could be made immediately and without new funding to increase the availability of existing inpatient resources. These strategically significant innovations have led to greater access to timely and appropriate care for people in crisis and brought King County quickly into compliance with the Supreme Court's ruling, while also identifying areas for future work.

In addition, these short-term efforts have helped establish a solution-seeking approach within the Task Force team. Members with a variety of perspectives, sometimes including competing interests, have brought new ideas and a collaborative approach to addressing the issues. This has resulted in the Task Force becoming a place where concerns and barriers can be pointed out and jointly explored in order to develop solutions that keep the system moving forward toward shared desired outcomes.

Access to Treatment

By mid-December 2014, before the effective date of the Supreme Court's ruling, King County was in compliance with the ruling: all individuals detained under the ITA either were placed directly into an E&T facility or received appropriate treatment under a permissible single bed certification. However, neither the Task Force members nor King County government are satisfied with merely complying with the ruling, as some people continue to receive their care in EDs and medical units.

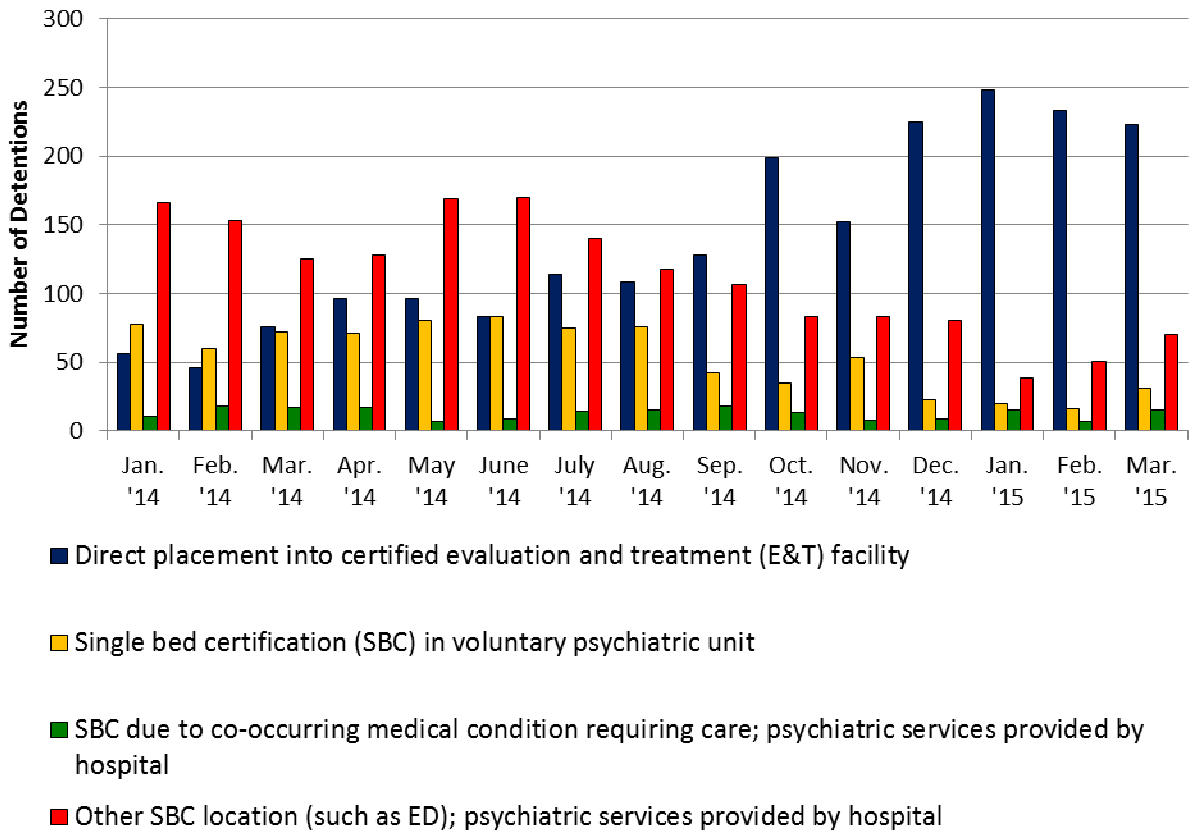
In order to measure its progress in providing appropriate and timely E&T services to all involuntarily detained patients, King County has been actively tracking the detention dispositions – the treatment settings where people are initially served after being detained by a DMHP – for all ITA cases since January 2014. The proportion of patients detained directly to an E&T bed versus initially detained in a non-E&T setting via SBC (not preferred but still permissible when timely and appropriate psychiatric services are being provided) has increased dramatically during the measurement period.[33]

Exhibit 7 shows the disposition of detentions by King County's DMHP unit, also known as Crisis and Commitment Services, from January 2014 through March 2015. The blue columns represent direct placement into an E&T bed – the preferred immediate outcome for a detained person. The other columns represent the three main other potential disposition options in King County, where a person is: (a) served initially in a voluntary psychiatric unit or psychiatric emergency unit on an SBC (yellow); (b) in a medical unit on an SBC due to co-occurring physical health issues (green); or (c) on an SBC in another setting such as an ED provided that timely and appropriate psychiatric care is being delivered (red).

Since the effective date of the Court's ruling, it has been the policy and consistent practice of King County to detain and immediately treat all individuals who have been found by a DMHP to meet ITA detention criteria, at either at an E&T or on a legal and appropriate SBC.

[33] King County MHCADSD reports.

Exhibit 7
King County Crisis and Commitment Services
(Designated Mental Health Professional Unit)
ITA Detention Dispositions by category, January 2014 - March 2015



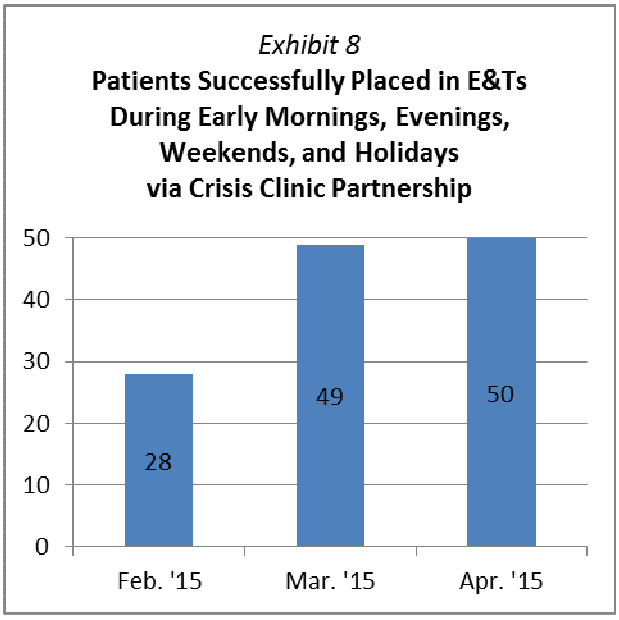
In the first quarter of 2014, near the peak of SBC utilization locally, only 20 percent of persons detained in King County immediately accessed E&T services. This proportion has gradually and consistently grown in the intervening quarters: by the first quarter of 2015, direct placement to E&Ts had reached 72 percent. This achievement reflects the collaborative approach between all facets of the involuntary treatment system to improve outcomes for those involved with ITA.

There has been a corresponding significant reduction in the use of SBCs. Now employed only within the bounds of the Supreme Court ruling, SBCs occurred 277 times in King County the first quarter of 2015, down 63 percent from a year earlier. Likewise, SBCs occurring outside psychiatric units or medical units – most often in EDs – dropped from 50 percent of all detentions to just 16 percent during that same period.

Although this dramatic reduction represents a huge success, the fact that SBCs are still being issued in King County about three times per day means that a serious E&T capacity problem still exists. Permanent expansion of treatment resources, along with service innovation and preventive efforts to reduce demand, are still critical needs moving forward.

Other Key Improvements

Extended Patient Placement Hours: One of the first areas of potential immediate improvement identified by the Task Force was the removal of delays in the inpatient placement processes for involuntary patients, most notably placement of patients into E&T beds only during weekday business hours. Through a new partnership with Crisis Clinic to provide after-hours patient placement coordination in collaboration with DMHPs, greatly expanded placement hours were piloted in December 2014 and fully implemented by February 2015, including morning, evening, weekend, and holiday staffing.



The immediate impact was that patients were no longer waiting overnight or over the weekend for proper placement. This resulted in shortening or avoiding altogether SBCs for certain individuals, while freeing up beds for others.

As shown in Exhibit 8, during just the first three months, 127 detained individuals who otherwise may have waited longer on SBCs received expedited placement into appropriate E&T beds as a result of this partnership.[34] This approach has worked so well that in early June, the Crisis Clinic took on daytime patient placement coordination as well, providing continuity and efficiency throughout the day and freeing up DMHP staff to serve more people in crisis.

New Patient Placement Decision Guidelines: A guiding principle of the Task Force's early work was to provide the right placement for the right patient. One of the most significant short-term efforts along these lines has been the establishment of a new set of guidelines for patient placement coordinators and DMHPs to use to help make sure each patient is placed in a facility that best meets his or her needs, rather than placing each patient in any available bed. Developed in partnership with area E&T facilities and hospitals, this new process encourages appropriate bed availability across the system. The premise behind the guidelines is to triage patients for placement based on the clinical presentation and facility level of care.

These guidelines, attached as Appendix E, spell out prioritization and exclusionary criteria for every E&T. Implementing these guidelines has resulted in patients triaged to the most appropriate treatment setting that best matches the patient's care needs.

For example, a newly detained patient with a new-onset psychosis or unexplained change in mental status may require a more extensive medical workup for clinical reasons. These patients need to be prioritized to an E&T that offers this service. Also, patients with significant co-occurring medical conditions will be triaged to a hospital-based E&T that can provide medical care on the psychiatric unit. At the other end of the complexity spectrum, a patient who may be well known to the system and does not have major medical concerns may be effectively treated in a freestanding E&T. Each E&T also has other subspecialties, such as adolescent care, geriatric care or co-occurring substance abuse treatment.

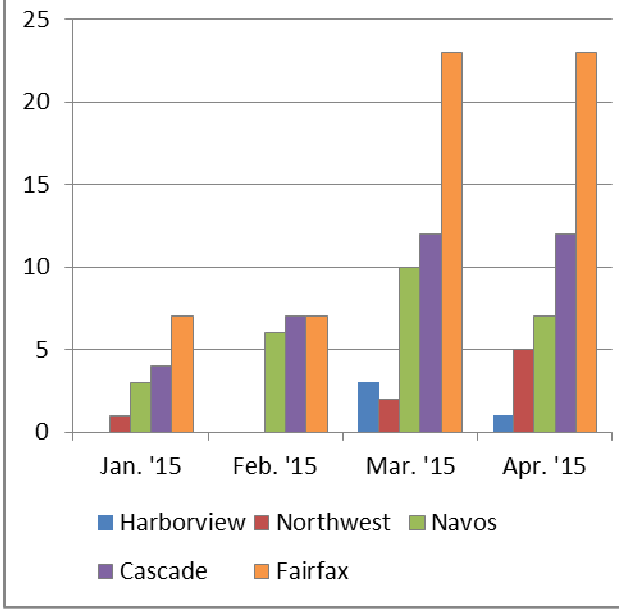
[34] Crisis Clinic reports to MHCADSD, February through April 2015.

Making these triage decisions at the time of detention contributes to more efficient throughput and transfer to an inpatient setting, as well as promoting quicker access to the hospital-based E&Ts.

To achieve these outcomes, E&Ts such as Harborview that are set up to care for the most complex patients had to take the risk to transfer their less acute patients to other E&Ts, permanently increasing the overall acuity of their patient population – a risk that was made possible via the cooperative context of the Task Force. As a result of this effort, patients are getting better care. For example, because young adults experiencing a new onset of psychosis are now prioritized to an E&T where a full workup can be provided, rather than served in the first available bed, their families are getting better information about the implications of the diagnosis and ways to manage it. Also, very complex patients that previously waited in EDs for very scarce beds that fit their range of needs are now receiving more complete treatment much sooner.

E&T Placement Troubleshooting: The Task Force routinely reviews the reasons given by E&Ts whenever they decline to accept certain patients. Systematic review by the Task Force of the numbers of declines and the reasons for them promotes coordinated decision-making and frequently generates constructive discussion about E&T facilities' needs and potential mitigation strategies to facilitate successful placement and treatment of higher-acuity patients.

Exhibit 9
ITA Clients Declined per Month by E&T Facilities



Between January and April 2015, declines by King County E&Ts occurred a total of 149 times. As shown in Exhibit 9, these declines came disproportionately from certain facilities. Fairfax Hospital declined patients a total of 69 times over four months, Cascade Behavioral Health 43 times, Navos 25 times, Northwest Hospital Geropsychiatric Center eight times, and Harborview Medical Center four times.[35]

The systematized data tracking and discussion by Task Force members generated increasing awareness of the differences between different E&T admissions policies and practices. In turn, this collective information and assessment created an avenue for coordinated feedback and advocacy with facilities whose decline reasons were explored by the Task Force. As decline behavior among the five E&Ts varies widely, these trends have triggered discussions with staff at Fairfax Hospital and Cascade Behavioral Health, who each decline more patients than the other three King County E&Ts combined.

[35] The increases in the raw numbers of declines system wide in March and April, as shown in Exhibit 8, may be attributable in part to some volume-related systemic factors, including a period from February 19 through approximately March 11 when Western State Hospital (WSH) was closed to new admissions due to a psychiatrist shortage – which left fewer local beds available during that period and thereafter as patients committed to WSH had to wait longer in community hospitals or E&Ts – as well as a typical seasonal increase in referrals to DMHPs each spring which results in a corresponding increase in detentions.

A full list of decline reasons given by all King County E&T facilities during this period, organized by facility and frequency, is included as Appendix F. Themes in E&T exclusionary criteria that have arisen so far have included:

- E&Ts' stated limits in caring for patients with additional care needs, often related to medical needs, medical equipment, or ability to perform basic functions such as activities of daily living;
- Unstated limits cited during the actual referral process, including HIV status, transgender identification, behavioral issues, acuity, or cognitive impairment; and
- Frank denials for persons diagnosed with dementia or developmental disability.

As part of the work of the Task Force, a weekly summary of E&T declinations is disseminated to E&T leadership and social work managers at community hospitals in an effort to highlight the broad range of stated and unstated exclusionary criteria that impact the efficiency of patient placement.

Although there remains room for continued improvement, system change is already evident. Providers have been very receptive to this more transparent process. E&Ts are sharing more details as to why they are declining patients; some facilities have been actively following up to find out why their institution declined to accept a person; and some hospitals appear to be accepting more acute patients than they did previously. The Task Force continues to deliberate regarding potential solutions to the issue of E&T declines.

Executive Expeditors: Despite these efforts, there are some patients who are challenging to place in E&T settings due to unique complexities in their cases. The Task Force has helped to identify executive staff as designated expeditors in each E&T to work with King County/Crisis Clinic patient placement coordinators to provide increased flexibility and help resolve situations where typical exclusionary criteria would appear to prevent their E&T from accepting a patient referral.

A common expeditor scenario may be a case where an E&T declines a patient for admission, and the referring facility wishes to challenge this decision. In these instances, leadership at the County may bring the case to the expeditor at the denying E&T with a request to revisit their decision. Another scenario may be the event when there are no identified open or appropriate beds in the County, but there is clinical urgency to place a patient. The expeditors may be contacted to explore potential openings in their facility including any existing patients who may be ready for discharge. The guiding principle for this process is to ensure that patients are placed as efficiently as possible and to press facilities to revisit some of their more limiting exclusionary criteria. The expeditor is ideally available at all times, and is typically the director, medical director, chief nursing officer, or chief executive officer of the E&T.

The expeditor process highlighted some key issues for the Task Force to continue to work through in the coming months. The process is currently being underutilized, as declination decisions are not reversed as often as the Task Force initially expected would occur through the expeditor process. In the coming months, the Task Force intends to build upon relationships between the E&Ts in order to bring together expeditor staff from all five E&Ts to refresh and refine this process, and to give further attention to each organization's exclusionary criteria.

Despite these challenges, several patients who would previously have been declined by an E&T have been accepted and promptly treated as a result of the expeditor process.

Moving Toward Centralized Capacity Reporting and Tracking: A centralized bed tracking and disaster communication system called WATrac, already in use by all King County hospitals and accessible 24-

hours per day, seven days per week, now provides a systematic method for tracking psychiatric bed availability. All five King County E&T facilities are using WATrac to report current psychiatric bed capacity according to specific intervals each day, and are working to provide more real-time bed status information.

Currently, E&Ts aim to update this information three times daily, which provides an estimate of capacity, but due to the speed with which bed utilization and needs can change, patient placement coordinators are following up by phone to confirm availability information. WATrac has its limitations: unexpected bed status changes that result from unexpected Court dismissal or discharge against medical advice may make data inaccurate, and the WATrac data structure is not yet set up to be sufficiently specific to fully meet all placement coordination needs (such as displaying the identified gender associated with available beds).

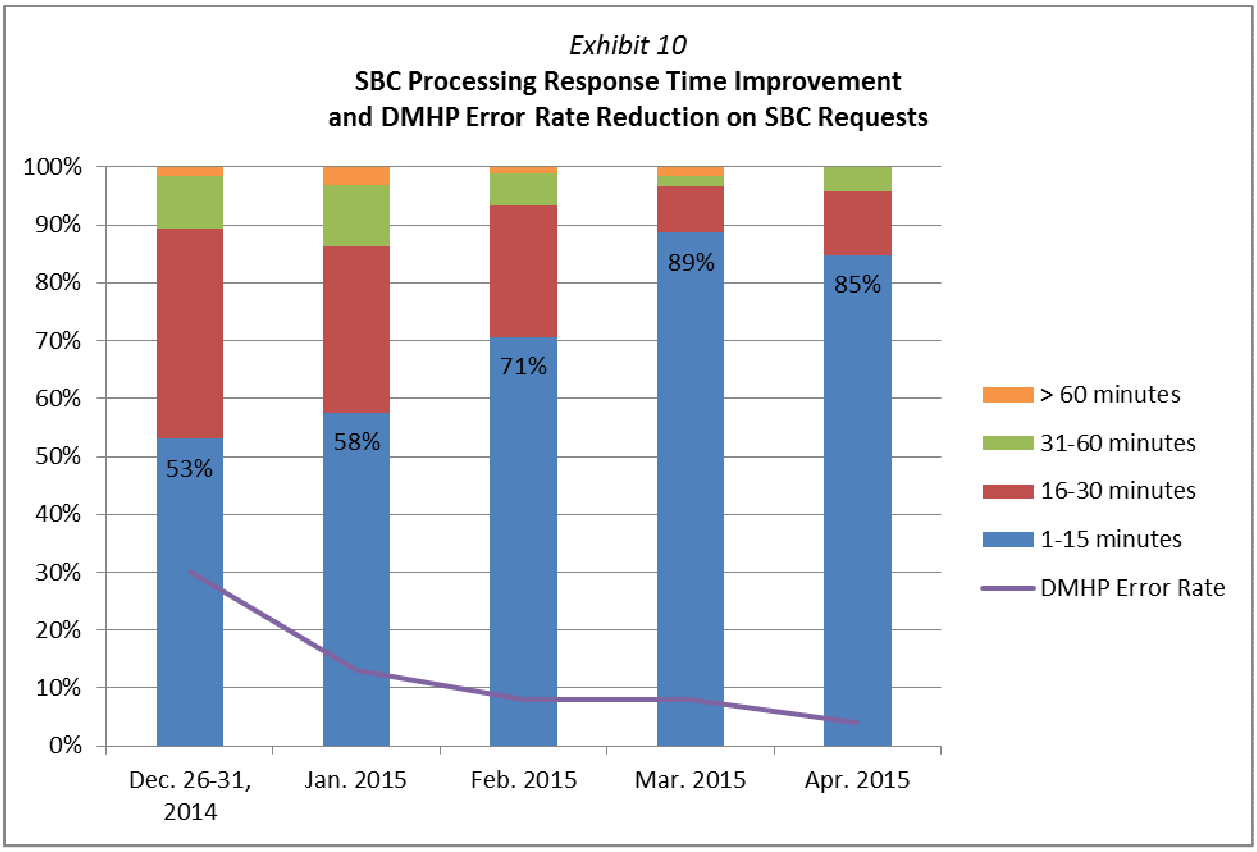
Since the reliability of WATrac psychiatric bed data to date has been uneven across the system, all five E&Ts have agreed to look for ways to institute real-time updates to the WATrac system as part of routine activities to be completed whenever a patient is discharged. Task Force members, along with DMHP managers throughout the state, have also engaged WATrac administrators in discussions about ways to optimize the system's use for this purpose. As these processes are implemented, the Task Force expects accuracy rates to increase.

Although there is room to refine WATrac, it is both critical to disaster preparedness – its original and primary purpose – and at identifying available beds. Even in its current state as a work in progress, utilization of WATrac promotes efficiency by providing a starting place for placement coordinators.

The Task Force recommends automated updating of the WATrac system at each E&T to improve accuracy and that it be expanded throughout the state, in efforts to communicate bed availability across county lines. As WATrac data begins to more closely match real-time capacity, it is likely to become a more powerful information-sharing tool between community hospitals, DMHPs, and E&Ts, and should contribute to more efficient placement. Because of the promise of this model, the state DBHR is asking RSNs from across the state to use the WATrac system to track psychiatric bed availability, following King County's example.

WSH SBC Approval Process Streamlining: SBC approval at Western State Hospital (WSH) was cited by multiple Task Force members as a significant obstacle to in helping detained people access appropriate treatment quickly, as the legal authority to hold the person is not in place until the SBC is in place. In 2014, DMHPs had to wait in hospitals, sometimes for hours, until a response arrived from the WSH unit that reviewed and approved SBC forms. This kept DMHPs from moving on to other referrals, thus slowing their overall response time.

In response, Task Force members engaged each other in honest, open, and forward-looking discussion to solve the problem. DCHS staff visited Western State Hospital (WSH) and along with Task Force members representing DBHR and WSH, worked with the staff responsible for reviewing and approving SBC requests to educate them about the link between this activity and timely patient care, and to provide training and improve processes to ensure that SBC requests are reviewed promptly. Along with these efforts to remove administrative and logistical delays has come the implementation of tracking mechanisms to measure improvement.



As a result, the rate of approval of SBCs within 15 minutes (the blue portions of each bar shown in Exhibit 10) increased dramatically, from 53 percent at the end of December 2014 to 89 percent in March 2015, and remained high during April 2015 at 85 percent. Since March 2015, 97 percent of SBCs have been approved within 30 minutes. In April, none of the 355 SBC requests processed by WSH took more than an hour to process. Also, as shown by the purple line, the error rate by DMHPs on SBC request paperwork – including using the old form, checking more than one option, or leaving out information – has dramatically decreased from 30 percent to four percent over that same short period. Together, these changes have expedited treatment access and greatly reduced the time DMHPs have had to spend waiting in hospitals for SBC approval before moving on to serve other people in crisis.[36]

In addition, multiple Task Force members advocated for legislation under consideration during the 2015 session. Engrossed Second Substitute Senate Bill 5649 further assisted with eliminating this point of delay by allowing DMHPs to presume approval of SBC requests and move on to other cases. This law went into effect in May. See Appendix G for more details.

ITA Court Collaboration: Throughout the Task Force's deliberations, working relationships and processes at the overstretched ITA Court have been a topic of significant conversation. To build on previous work undertaken by the Court to address its dramatically increased workload, the Task Force hosted an honest and respectfully energized discussion among ITA Court prosecution, defense, and judges, along with the other Task Force members. The discussion focused on the ITA Court's unique challenge of working together within the involuntary legal system to facilitate wise and timely health care and safety

[36] DSHS State Hospitals Single Bed Certification Databases and WSH 24-hour Single Bed Certification Reports, May 4, 2015.

decisions that balance individual due process rights with treatment need. Despite different points of view among the various participants, there was broad agreement on the principle of bringing appropriate and timely treatment to people who need it, increasing collaboration between prosecution and defense (especially pre-trial), and advocating for funding to add more DMHP staff and to establish more upstream solutions such as crisis intervention.

Several potential next steps were identified, including joint training for ITA Court staff, attorneys, and judges; and exploring ways to facilitate better coordination and problem solving before trial. Follow-up conversations among ITA Court-affiliated Task Force members have revealed significant interest in gathering together Court participants, non-Court partners, and consumer groups who could share the direct experience of individuals in the ITA system, to address processes and capacity challenges that pressure the Court and affect detained individuals' treatment access as well as their experience of the legal system. The Task Force endorses this approach.

Partnering with Community Hospitals: Coming alongside King County and the Task Force in their commitment to ensure that any person who meets the ITA's detention criteria receives timely and appropriate care, almost all community hospitals in our county have accepted the SBC as a mechanism to temporarily and legally meet patients' medical and psychiatric needs and to ensure continuity of care, despite the fact that payment mechanisms are not in place to reimburse them consistently for these services.

This success is due in large part to Task Force members' efforts in fall 2014 to build collaborative relationships wherein hospitals took ownership of their role in assisting with this treatment access crisis by agreeing to provide psychiatric care to individuals temporarily held on SBCs. In fact, in this spirit of partnership, hospitals have influenced each other to do their part to shoulder this responsibility. This cooperation from hospitals in providing legally and clinically appropriate SBCs has been absolutely critical to King County's compliance with the *D.W.* ruling and the prompt delivery of individualized psychiatric treatment to every King County resident who meets detention criteria under the ITA.

King County's positive experience regarding community hospital support for SBCs is an outlier in the state. A variety of reasons may be contributing to this, including: a lack of professional capacity in some hospitals to provide adequate care including individualized mental health treatment plans and necessary psychiatric prescriptions. Lacking hospital partners willing to hold individuals on legal SBCs and provide timely and appropriate mental health treatment, other communities may be left with only undesirable options: either detaining people and transferring them to a faraway E&T, often without means to get people back home after the end of the detention or commitment period or to connect them with local resources at the time of discharge; using a notification process to document that patients meet detention criteria but no beds are available, meaning that people in crisis are not detained at all and do not receive needed treatment; or seeking justification to hold the person within the Emergency Medical Treatment and Labor Act (EMTALA), which guides hospitals to stabilize patients before discharging them, in hopes that a voluntary placement can be negotiated with the patient.

Medium- and Longer-Term System Improvements

The Task Force-initiated improvements, in combination with the new inpatient- and diversion-focused programs and initiatives described earlier in this report, have been very effective in improving inpatient treatment access, eliminating illegal boarding, and reducing overall SBC use. However, in order to further develop and work towards achieving the ideal future state of preventing use of the ITA whenever possible, along with direct inpatient E&T access and SBC usage only when clinically beneficial, the Task Force's system design work on medium- and longer-term options is critical. These development efforts include identifying new approaches to prevention and intervention services throughout the continuum of care, along with exploring new or realigned resources to achieve outcomes.

The following areas are identified by the Task Force as medium- and longer-term improvements to work toward. The areas identified below will be a significant focus of the team in the latter half of 2015 and into 2016, with design and problem solving sessions necessary. Subsequent reports will detail progress and challenges in these areas.

Diversion and Front-End/Upstream Re-engineering

The Task Force is committed to identifying opportunities to divert individuals to the degree possible from the ITA system to appropriate community-based options. Additional work on this area is needed, as the Task Force will be considering a range of options and potential next steps, including lessons that can be learned from other innovative efforts.

Crisis and Commitment Enhancements: Further improvements within King County's crisis and commitment functions that decrease demand for ITA and improve DMHP ability to respond to cases are being developed for consideration by the Task Force. One idea being explored is setting up a pre-screening process by which appropriate cases can be diverted to the Crisis Solutions Center, Mobile Crisis Team, and other least restrictive alternatives before DMHP staff are involved. Assisted outpatient treatment procedures coming out of the 2015 legislature, supported by some Task Force members, may also provide DMHPs with more ways to engage people in treatment before hospitalization.

Crisis Intervention Training and Diversion Resources: The Task Force is interested in expanding crisis intervention training for first responders along with diversion resources. With limited crisis diversion beds available now, the Task Force wants to ensure that trained personnel have sufficient alternatives to which they can refer people in crisis, so that the promise of diversion does not become a source of frustration to public safety or ED partners.

Competency Restoration: Task Force members participate with County and Seattle Courts, police, jail officials, and DBHR on workgroups aiming to improve competency restoration processes. The *Trueblood* ruling and associated legislation has accelerated activity in this area. In addition, members are in discussion with system leaders regarding possibilities for outpatient competency restoration.

Models of outpatient competency restoration currently under consideration by the state include multiple levels of intervention such as walk-in clinic services, residential or group home services, or in-custody competency restoration within jails (which is more controversial). The Task Force is considering how it may be best be able to assist with the state's challenge to deliver timely competency evaluation and restoration.

Familiar Faces: The Task Force plans to build upon the thoughtful work of the King County Health and Human Services Transformation Plan individual level strategy, Familiar Faces. Familiar Faces is focused on holistic services for people who cycle through King County jails four or more times in a rolling 12 month period (approximately 1,300 per year), 94 percent of whom also have either mental health conditions and/or substance use disorders.

The Task Force intends to explore the degree to which Familiar Faces improvements may also benefit those who frequently encounter the ITA system. To the extent appropriate, the Task Force intends to partner with Familiar Faces to determine the degree to which frequent users of EDs and/or people with multiple psychiatric hospitalizations per year overlap with the Familiar Faces target population. Additionally, members intend to propose ideas to help eliminate barriers to prompt and responsive care for this crossover population, including preventive solutions; and develop additional strategies for those individuals who encounter the ITA system or other emergency services but have less contact with the criminal justice system.

During the second half of 2015, the Task Force plans to engage in further brainstorming/design sessions to further develop its recommended upstream solutions and diversion approaches.

Alternative Processes and Resources for Patients with Dementia, Developmental Disabilities, and Traumatic Brain Injury

At times, people living with dementia, developmental disabilities, or traumatic brain injury become involved with the ITA process as a result of crisis behaviors stemming from their condition, even though inpatient psychiatric care is most often not an effective long-term intervention for such individuals. The Task Force is seeking to better understand how the intent and statutes of ITA impact individuals with a diagnosis of dementia or any mental disorder. So far we have found statutory language stating that having a diagnosis of dementia, in and of itself, is not a valid reason for detention. Dementia also does not make an individual ineligible for detention based on the condition alone if the individual otherwise meets the criteria for detention.

The statutory definition of mental disorder is any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions. Dementia is a condition in which there is an impairment of cognitive faculties, such as memory, concentration, and judgment, sometimes accompanied by emotional changes, resulting from an organic disease or a disorder of the brain. Similar to other mental disorders (e.g., schizophrenia, bipolar disorder, or traumatic brain disorders) there currently is no cure for dementia, though there exist interventions in both inpatient and outpatient settings that can reduce agitation and other behaviors that can lead to harm to self or others. Also similar to individuals with other mental disorders, most individuals with dementia do not experience a deterioration of their cognitive or emotional faculties that meets this threshold of dangerousness or grave disability.

The intent of the ITA, which includes protection of the public from and safe guarding individual rights of those with mental disorders, is met when individuals with dementia are detained through the process. The intentions of the statute to provide appropriate and timely treatment and to provide continuity of care for persons with serious mental disorders are not as clearly met. The requirements for treatment outlined in the statute are not consistent with best or evidence-based practice for persons with dementia and who are also dangerous to themselves/others or gravely disabled.

The Task Force is working with the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to better understand their respective processes that result in individuals with dementia not being able to reside safely in the community, particularly if their health insurance is Medicaid or if safe and appropriate care in the community is not adequately funded. The current evidence base suggests that specialized units for individuals with dementia may not provide better care or outcomes whereas providing training and support for staff in skilled nursing facilities may be more effective. Thus, alternatives to ITA hospitalization for these individuals, whether medical or psychiatric, are under review by the team.

The Task Force is also working to understand guardian ad litem statutes and practices as they relate to individuals with dementia. A guardian ad litem (GAL) is an individual appointed by a court to assist the Court and the individual during a guardianship petition process. GALs cannot make decisions on behalf of the individual except in emergency life-saving medical services. The process for appointing a guardian is time consuming and is limited in decision making for psychiatric care or other involuntary care decisions. For example, a guardian cannot consent to involuntary residential admissions or to care that restricts freedom of movement. Task Force members are working with the King County Bar Association to explore opportunities to amend GAL and guardian decisional authority in a manner that safe guards individual rights and improves current processes that result in more restrictive care settings than, perhaps, an individual requires.

Finally, the Task Force has initiated outreach to several government agencies and national non-profit mental health and disability law groups to explore how other states care for individuals with dementia who need inpatient treatment.

Should the Task Force move forward with specific recommendations in this area, the team recognizes that system improvements related to competing statutes and regulations (nationally and within Washington State) will need to be resolved. Additional stakeholder participation will be necessary, as is the case with many of the areas under consideration for recommendation.

Workforce Support and Development

Major workforce challenges negatively impact the publicly funded behavioral health care system. Trained, licensed, and qualified staff are difficult to find and/or retain in community provider organizations, as they are recruited away by entities like the Veteran's Administration and private health care systems that can pay more and/or forgive student loans. It is also difficult to recruit psychiatrists, nurse practitioners, and nurses to public sector behavioral health due to a small candidate pool and challenges in offering competitive salaries. The behavioral health workforce, particularly in public sector settings, also experiences high turnover due, in part, to burn out, stress, and lack of social support. Ongoing reductions in funding for public behavioral health contribute to staff turnover and recruitment challenges.

This increases the likelihood that people will require inpatient care, as it is difficult to maintain therapeutic relationships and implement evidence-based practices when clinicians do not stay at agencies to work with clients over time. Staffing vacancies in outpatient settings make it difficult for patients to access services. This leads individuals to seek care in emergency departments. The inadequate workforce has been a factor in the lack of capacity at both the state hospitals and local certified E&T programs, which has contributed to psychiatric boarding. The Task Force has reviewed

national as well as local data regarding the status of the workforce in public behavioral health settings. Challenges with the public behavioral health workforce exist not only within King County, but also across the country.

The Task Force is currently exploring best practices for reducing turnover in public behavioral health settings, including opportunities for system-wide support for continued professional development, staff resiliency building, and heightened recognition by the public and policy makers of workforce contributions. Effective solutions for recruitment have been demonstrated in the areas of loan repayment or forgiveness programs. Optimizing "top of the license" practice and continued development of paraprofessional roles can help reduce the quantitative need for positions that require advanced, professional credentials. A more long-term approach includes formal partnerships with schools that are training the future workforce, engaging students early in the training process about a career in public behavioral health, and campaigns for second career pathways in public behavioral health.

While many of the system challenges associated with retention and recruitment are related to economics, some are not. Initiatives are under way related to workforce development of specific professions, populations, and communities that could be more strategically focused on a public behavioral health path. The Task Force plans to continue to help identify the market forces that impact the current workforce and reach out to those leading workforce development initiatives.

Behavioral Health Integration

Multiple Task Force members are engaged in various aspects of the integration of mental health and substance abuse by 2016, and with longer-term planning for integration with physical health care. The Task Force actively supports the triple aim of better health, better care, and lower costs that is being pursued at the state level via such plans as Healthier Washington, which will transform the health system by:

- Building healthier communities through a collaborative regional approach;
- Ensuring health care focuses on the whole person, via physical and behavioral health integration; and
- Improving payment mechanisms for services, including value-based purchasing.

Integration of Mental Health and Substance Use Disorders Treatment by 2016*:* Task Force members representing King County DCHS are actively working to be ready to function as the Behavioral Health Organization (BHO) for the King County region beginning April 2016. This will allow the County BHO to provide more holistic care to individuals with behavioral health disorders, including more flexibility for providers and increased access to treatment for co-occurring disorders. It also provides a unique opportunity to improve upon the current behavioral health system and drive toward increased standardization and quality of care as well as more outcomes-driven care. This includes helping to ensure that providers understand and are ready to operate under the new requirements.

Furthermore, Task Force members are or will be providing strategic consultation on such formative issues as benefit model design, provider network development, data system development, and will provide input on rate development later this year, as these are all key elements of King County's detailed plan to become an integrated BHO next year. A timeline for this work is on the following page.

Task	Timeframe
Benefit model design	June 2015
Data system development	Ongoing
Rate development	Summer/Fall 2015
State releases detailed plan	July 1, 2015
Network development	Ongoing
Detailed plan due to the state	October 31, 2015
Behavioral Health Organization services begin	April 1, 2016

Physical and Behavioral Health Integration: As BHO preparations are well under way for 2016 implementation, work is also under way to integrate physical and behavioral health care. A consultant has been engaged to help determine the optimal role for King County government in the administration and delivery of fully integrated medical, mental health, and substance abuse treatment services. A final report, based on interviews with a number of partners and key stakeholders, including individuals participating in services; studies of current operations and infrastructure for mental health and substance use disorder services; and a national review of integrated care financing and model analysis, is almost finished. Using this report to guide the conversation, Task Force members and other community partners will be providing advice toward a path forward for full integration is developed.

Task Force representatives from King County DCHS and the Executive's Office are working with other members and community partners to launch a Physical/Behavioral Health Integration Design Committee in June 2015, which includes Medicaid managed care plans, medical providers, behavioral health providers, local and state government, consumers and advocates, and other key stakeholders will help design key components of an integrated system of care, create shared outcomes, performance measures, and accountability mechanisms and develop agreements around shared risk and shared savings. This will be a formal subcommittee of our regional Accountable Community of Health (ACH). This work also ties into the work of the Familiar Faces initiative described in the Diversion and Front-End/Upstream Reengineering section above.

The Task Force emphasizes lessening the need for crisis beds and ITA beds through preventive care. The move to the BHO design, as well as the broader ACH approach, will help achieve reduction of crisis demand through the use of preventive services as well as increased use of evidence-based, research-based and promising practices, and increased performance measurement and accountability. The Task Force strongly supports these efforts and intends to remain engaged and continue to influence them as they develop.

Legislative and Policy Changes

The Task Force committed to establishing a system for on-going coordination and discussion of legislative issues across disciplines and perspectives. As the Task Force includes a cross-section of many key system players, it determined that establishing a team from among its membership to work on legislative issues is the right approach.

In order to improve overall services for individuals in mental health and substance abuse crisis, it will set up a structure to:

- Proactively develop and propose legislation;
- Share and analyze data (such as commitment data, Court data, jail data, and/or hospital utilization data) that can be used to assist in evaluating system impacts; and
- Determine the effects of legislation and policy changes.

As a starting place for this collaborative communication during the 2015 legislative session, the group reviewed and discussed policy bill analysis produced by King County DCHS, including expected policy and fiscal impacts, and also received timely briefings on relevant aspects of House and Senate budget proposals.

The Task Force plans to schedule a post-session meeting to discuss 2015 legislative action on policy bills, budget issues and to evaluate impacts of legislation, and another meeting to develop coordinated legislative positions and issues in preparation for the 2016 Legislative Session. These items will be developed into an articulated legislative agenda. Interim session activities could include meetings with legislators and other stakeholders to work strategically on legislative priorities.

During state legislative sessions, the Task Force will schedule regular conference calls involving its priority area subgroup as well as staff from King County Government Relations. Discussions at these gatherings will include upcoming legislation, committee meetings and bill testimony, and King County's position. Email updates to the full Task Force will also be employed as a mechanism to share data, bill impacts, and legislative review from each member organization's perspective.

One understandable challenge the Task Force faces results naturally from the different aspects of the adversarial system of justice represented among its membership, as well as the different concerns of individuals responsible for different aspects of the continuum of care. It is not uncommon for there to be divergent opinions from different system players on legislation – which can sometimes lead to conflicting advocacy on the same policy even when broad goals are shared.

To address this, the Task Force has agreed to concentrate its shared legislative work on client-focused services to improve the system of care. Even so, the Task Force sees benefit in engaging in ongoing conversation about members' divergent opinions, which will lead to a greater understanding of each system's perspectives. Focusing on the client may lead to compromise and agreement on legislative positions.

Task Force Budget Recommendations Prior to 2015 State Legislative Session: As noted in the 2015 Legislative Session Input section above, the convening of the Task Force and its early brainstorming work in fall 2014 dovetailed with an opportunity to provide input to the Governor's budget proposal for the 2015-17 biennium. In November 2014, the Task Force recommended the following 2015 priorities to the Governor's policy advisor:

- Capital funding for inpatient psychiatric facilities, including E&T construction and hospital bed conversion;
- An integrated ITA system, including secure detoxification facilities for people with substance use disorders;
- Increased state hospital bed space and locum tenens staffing;
- Increased rates for substance use disorders treatment providers;

- Expansion of the peer bridger program;
- Funding for tele-psychiatry not tied to individual patients;
- Centralized medical clearance; and
- Extension of the emergency Washington Administrative Code addressing SBCs.

Member Advocacy During the 2015 Session: Many task Force members provided advocacy and information to policymakers on most of the major behavioral health policy legislation that received serious consideration during the 2015 state legislative session. Although the Task Force's broad membership meant that testimony and advocacy was not uniform, trends did emerge among members' positions. Member advocacy on policy bills is summarized in Appendix G, while advocacy on budget items is captured in Appendix H.

Outcomes from the 2015 Session: Many of the Task Force's recommendations before and during the 2015 legislative session – especially capital funding, the integrated ITA system, and increased state hospital capacity – were prominently featured in budget proposals and/or policy bills during the session.

- **Significant Policies Enacted This Year:** Procedural fixes to timelines in the ITA law, including timeline adjustments, presuming SBC approval, and decisions of ITA cases based on merits instead of timeline violations, were all adopted. Assisted outpatient mental health treatment along with associated changes to less restrictive alternative treatment including revocation and modification of such orders also passed.

- **Significant Policies Still Under Consideration:** As of this writing, state hospital capacity increases and capital funding for E&T beds were in both chambers' budgets.

- **Progress Toward Enactment:** Meanwhile, the integrated ITA system policy and secure detoxification resources, raising the tobacco purchase age, and a bill to offer certificates of restoration of opportunity for individuals in recovery who have criminal histories, all garnered strong support and serious consideration throughout the regular and special sessions.

- **Results In Other Key Budget Areas:** As of the writing of this report, flexible non-Medicaid mental health funds, Medicaid rates, Program for Adaptive Living Skills (PALS) funds, and Criminal Justice Treatment Account (CJTA) funding were slated for reductions despite the Task Force's advocacy. However, in revised budget proposals under consideration at the time of the writing of this report, proposed non-Medicaid mental health cuts were less severe than the amounts originally proposed by the Senate.

- **Likely New Funding for ITA Policy:** In addition, both the House and Senate budget proposals did include significant new funding for increased utilization costs associated with ITA implementation including the new mandates stemming from the Supreme Court ruling and the state's emergency rule regarding SBCs. These broadly purposed funds would complement any specific funding that may be designated to fund the ITA changes resulting from policy bills, including assisted outpatient mental health treatment, and review of DMHP decisions when family members petition the ITA Court. Questions remain as to whether the proposed funding is commensurate with the actual resources needed for successful execution of the bills.

- **New Policies to Implement:** The primary new challenges arising from the state legislative session for this Task Force will be the implementation of several new ITA laws, most of whose procedures and funding mechanisms must still be determined. One of the most significant policies to emerge this year included ITA Court review of DMHP detention decisions when petitions are submitted by family members or guardians to overturn them, including a 48-hour response timeline for DMHPs. Task Force members are already working together to design implementation processes and gather data to assess whether additional funding is needed. Managing potential funding reductions in state non-Medicaid mental health would also present some difficulty for the service system, as King County does not maintain excess reserves.

- **New Partnerships with Elected Officials and Advocates:** One of the major outcomes from the session was the formation of new or strengthened partnerships between Task Force members, legislators, and other advocates around issues that affect King County's behavioral health community. Multiple Task Force members were called upon by state elected officials and legislative staff, individually or in small workgroups, to provide input on bills and budget issues before and during the session.

Working Toward Shared Priorities for 2016: Using the collaborative information-sharing process envisioned by its legislative and policy changes work group, the Task Force envisions working together to identify shared legislative priorities for 2016, where the joint endorsement of the Task Force can increase the impact of members' advocacy. Some potential issues, such as workforce development promotion initiatives like loan forgiveness or tuition reimbursement, are already being discussed for 2016.

Conclusion and Next Steps

The behavioral health world is rapidly evolving. Actions such as state mandated behavioral health integration, court rulings and legislative statute changes, along with the implementation of the Affordable Care Act, require King County and its partners to work together to make meaningful system improvements. At the same time, the population of King County is growing along with efforts to divert those living with mental illness from the justice system and the ITA system.

Despite this shifting environment, the Community Alternatives to Boarding Task Force has had notable successes in engaging a wide range of partners to collaboratively implement changes to long-standing involuntary treatment system processes. The changes include:

- Extending the times when individuals detained under the ITA can be placed;
- Establishing countywide placement criteria to match patients to the right treatment setting for their particular needs;
- Engaging multiple organizations to begin centralizing bed capacity tracking and reporting;
- Investigating and streamlining approval processes at the state hospital;
- Working to increase collaboration within the ITA Court; and
- Engaging community hospitals on a voluntary basis to assist with providing appropriate treatment.

This work has resulted in major progress in providing the preferred treatment environment for individuals in need of involuntary care in King County, including compliance with the Supreme Court ruling that outlawed boarding for detained patients. These efforts have also solidified the partnerships that are necessary to design and implement long-term system changes and alternatives that can reduce demand. Capitalizing on this collaborative culture, the Task Force has begun long-term work in strategically significant areas where it can have broad and lasting impact.

The momentum that the Task Force has generated to make meaningful improvements to the ITA and community alternative systems will carry forward into the next phases of our work. The Task Force will continue to develop and provide strategic consultation regarding the ITA and crisis systems, including regarding the deployment of program resources, such as evaluation and treatment programs, to prevent boarding. The group remains committed to responding quickly and collaboratively to any unforeseen developments that may affect its target populations.

Components of the Task Force's next phases of work include building on cross-system collaborations and leveraging other work and improvements. Members intend to revisit visioning, priority areas, and environmental assessment to inform the development of recommendations. The Task Force's goal is to identify preliminary system design recommendations that can shape advocacy and decision-making during three unique opportunities for influence during the first half of 2016: the state legislative session, MIDD renewal discussions, and behavioral health integration implementation including physical health integration planning.

The Task Force's next report to the King County Council, due on January 30, 2016, will provide further details on its progress and may include some initial recommendations. In accordance with the request in Council Motion 14225, final detailed recommendations will be presented on June 30, 2016.

Appendix A: Motion 14225

King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

September 16, 2014

Motion 14225

Proposed No. 2014-0383.1 **Sponsors** Lambert

A MOTION requesting that the executive utilize an existing task force convened to develop sustainable solutions to the psychiatric boarding crisis, to review and recommend short- and long-term sustainable solutions for prevention, early intervention and least-restrictive alternatives for individuals in mental health and substance abuse crisis.

WHEREAS, the personal and public tolls related to individuals experiencing mental health and substance abuse crises are growing each year, and

WHEREAS, the boarding of psychiatric patients in hospital emergency rooms and acute care centers because space is not available at certified psychiatric treatment facilities is a major problem in King County, with over sixty-four percent of involuntarily detained individuals held on single bed certifications in 2012, and

WHEREAS, Washington state has broadened the criteria for involuntary commitment of people with mental illness, while simultaneously closing hospital wards, cutting state funding for mental health treatment and failing to fund bed space for inpatient psychiatric treatment, and

WHEREAS, since 2007 the caseload for King County's involuntary treatment court has grown faster than any other category of superior court cases, increasing by fifty-four percent according to 2013 data, and

WHEREAS, Washington state ranks near the bottom of the country for psychiatric treatment beds per capita, ranking forty-seventh of all states, and

WHEREAS, on August 7, 2014, the Washington state Supreme Court ruled that hospital boarding of individuals in mental health crisis, absent medical need, is unlawful, and

WHEREAS, through policy, programs and services, including the programs and services funded in part by the mental illness dependency sales tax, King County is taking action to increase mental health and substance abuse treatment capacity to prevent mental health and substance abuse crises from occurring and to provide treatment in the appropriate setting, and

WHEREAS, without a reduction of demand for, and adequate funding of, mental health and substance abuse crisis services, the mental health and substance abuse systems of King County and the Washington state face both human and fiscal crises, and

WHEREAS, the King County executive and the Governor of Washington state have jointly convened a task force to work with hospitals and mental health and substance abuse treatment providers and other community stakeholders to develop and bring to state lawmakers short- and long-term sustainable solutions to address psychiatric boarding;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. The executive is requested assist the task force to find short- and long-term sustainable solutions that: increase the use of least restrictive alternatives for individuals in crisis, thereby reducing the demand for involuntary treatment, including the demand for involuntary treatment court services; provide for successful reentry into the community for individuals who have received services from psychiatric hospitals, including mental health and substance abuse treatment; and focus especially on the continuum of prevention and intervention services.

B. The task force is requested to submit a final report to the executive and the council on June 30, 2016, detailing findings and recommendations on the following matters:

1. Identification of services, programs, and protocols necessary for King County to reduce of demand for involuntary treatment services, including involuntary treatment court services

2. Identification of the continuum of reentry services from psychiatric hospitals into the community, including mental health and substance abuse treatment services; and

3. Identification of prevention and intervention services and least restrictive alternatives for individuals in crisis.

C. The task force is requested to provide progress reports to the executive and the council describing the progress and findings of the task force as it develops and reviews recommendations for the final report. The progress reports are due June 30, 2015, and January 30, 2016. The reports to the council must be filed in the form of a paper original and an electronic copy with the clerk of the council, who shall retain the original and

Motion 14225

provide an electronic copy to all councilmembers.

Motion 14225 was introduced on 9/8/2014 and passed by the Metropolitan King County Council on 9/15/2014, by the following vote:

Yes: 8 – Mr. Phillips, Mr. Gossett, Ms. Hague, Ms. Lambert, Mr. Dunn, Mr. McDermott, Mr. Dembowski, and Mr. Upthegrove
No: 0
Excused: 1 – Mr. von Reichbauer

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Larry Phillips, Chair

ATTEST:

Anne Noris, Clerk of the Council

Attachments: None

Appendix B: Task Force Charter

Objective: Ensure that all King County residents experiencing mental health and/or substance abuse crises have access to prevention, intervention, and least restrictive treatment services as needed and to community alternatives as appropriate.

Charge: This task force is charged with developing solutions for individuals in mental health and substance abuse crisis focusing on prevention, intervention, and least restrictive alternatives. Reflective of the statewide nature of this group, the members of this task force will collaboratively seek solutions for broad policy issues, solicit and generate creative ideas, and develop and share recommendations that may be implemented in King County and in other communities. Task force members commit to developing broad partnerships, creating bigger and achievable goals, using and sharing better data, and being prepared to take bold action that delivers results for the most vulnerable in our communities.

Task Force Guiding Principles: The work and recommendations of this Task Force will be informed by the following guiding principles:

1. Family, and individually focused;
2. Consumer informed;
3. Based in the principles of recovery and resiliency and reflect King County's behavioral health system's trauma informed approach to services;
4. Shared ownership of the system and continuum by providers, consumers, and the County;
5. Leverage other resources whenever possible;
6. Aligned with opportunities under the Affordable Care Act and health reform;
7. Equity and social justice oriented;
8. System focused, emphasizing increased efficiencies and effectiveness; and
9. Integrates behavioral health and primary care when possible.

Background and Overview: Crisis is costly for individuals who find themselves in a mental health or substance abuse crisis: costly in both human and financial terms. The publically funded behavioral health system that is responsible for serving individuals in crisis is complex, involving multiple systems (medical, criminal justice, and federal, state, and local governments) and stakeholders (providers, advocates, families). The involuntary treatment system is perhaps the most intimidating and rigid for individuals and families who find themselves in its midst.

The Washington State Involuntary Treatment Act (ITA) allows for people with mental disorders to be civilly committed against their will for defined periods of time – 72 hours, 14 days, 90 days, and 180 days[37]. In King County, a Superior Court adjudicates the civil commitment cases in the county's ITA Court, while ITA Court operations occur in partnership between the Superior Court, the Department of Public Defense, the Prosecutor's Office, the Department of Community and Human Services, the Department of Judicial Administration and the Sheriff's Office.

[37] *RCW 71.05 (adults) and RCW 71.34 (youth under 18)*

The Process of Mental Health Involuntary Commitment: Under state mental illness laws, there are specific circumstances where a person can be considered for involuntary psychiatric hospitalization if, as the result of a mental disorder, one of the following circumstances exists:

1. If someone presents a substantial risk of harm towards others or themselves; or
2. If someone presents a substantial risk of damaging someone else's property; or
3. Someone is in danger of serious physical harm because he or she cannot provide for his or her essential needs of health and safety.

King County's Crisis and Commitment Services section of the Mental Health, Chemical Abuse and Dependency Services Division of the Department of Community and Human Services conducts evaluations of people for possible involuntary detention in psychiatric facilities for mental health treatment. The Crisis and Commitment staff who perform these duties are all employed by the county and are referred to as Designated Mental Health Professionals (DMHPs). The evaluation by DMHPs is intended to protect the rights of individuals while assuring prompt evaluation and treatment for persons with serious mental disorders who pose a danger to themselves or others. Anyone who is within the boundaries of King County can be referred for involuntary treatment services.

Under Washington State law, the County, as the Regional Support Network, is legally obligated to evaluate individuals within statutorily defined timeframes and detain anyone who meets the statutory criteria for involuntary commitment and whose needs cannot be met by any less restrictive alternative. Furthermore, the County is required to detain the person in a facility in which the person can receive adequate psychiatric care. These are Evaluation and Treatment (E&T) facilities certified by the State. The County risks significant liability if the person who has been determined to be a danger to him/herself or others is not detained.

Since 2007, the caseload for King County's ITA Court has grown faster than any other category of Superior Court cases, increasing by 1,303 filings or 54 percent from 2007 to 2013. The growth translates to increase demands for staff, judicial officers, space and other costs that are borne by the mental health fund making less funding available for DMHP staff and/or treatment. The caseload increase is also directly related to the demand for involuntary treatment psychiatric beds.

The Process of Substance Abuse Involuntary Commitment: Substance abuse ITA laws fall under a separate statue (RCW 70.96A.140) and differs significantly from the mental health ITA process. When a designated chemical dependency specialist receives information alleging that a person presents a likelihood of serious harm or is gravely disabled as a result of chemical dependency, the designated chemical dependency specialist, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of the information, may file a petition for commitment of such person with the superior court, district court, or in another court permitted by court rule.

Boarding: Washington ranks 47th in the nation in inpatient psychiatric beds per capita, and there has been a significant reduction in psychiatric hospital bed capacity in the state in recent years while the population has grown.[38] This has created a severe shortage of inpatient psychiatric beds and a crisis of access to the care that people detained under the Involuntary Treatment Act (ITA) desperately need.

[38] M. Burley. (2011). *Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts* (Document No. 11-10-3401). Olympia: Washington State Institute for Public Policy.

The lack of inpatient beds, ITA law changes, and other factors have resulted in the use of single bed certifications (SBCs) for individuals temporarily detained in hospital emergency rooms and medical units while awaiting an appropriate bed to which the person can be transferred – a phenomenon that occurred 2,469 times in King County alone in 2013.

The State Supreme Court ruled in August 2014 that using SBCs solely due to insufficient inpatient capacity – commonly known as "boarding" – is illegal. The Court's ruling created a unique opportunity to address this crisis.

Drivers: There are a number of factors motivating the focused effort of this task force to address prevention, early intervention, and least restrictive alternatives for individuals in crisis. These elements offer multiple opportunities to achieve behavioral health system changes. They include but are not limited to:

- *New parity legislation*: The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care.
- *Affordable Care Act*: The Affordable Care Act further expands the MHPAEA's requirements by ensuring that qualified plans offered on the Health Insurance Marketplace cover many behavioral health treatments and services. It also includes prevention, early intervention, and treatment of mental and/or substance use disorders as an "essential health benefit" (EHB) that must be covered by health plans that are offered through the Health Insurance Marketplace. The ACA also significantly expanded Medicaid coverage. In Washington State, a potential enrollment increase of about 325,000 new clients over several years is anticipated.
- *Mandated integration of behavioral and physical healthcare*: During the 2014 legislative session, the Legislature passed Senate Bill 6312 that integrates how the state purchases mental health and substance abuse services. The legislation mandates that primary care services be available in mental health and chemical dependency treatment facilities and vice versa. It also creates financial incentives for local governments to "opt in" to full integration of behavioral health with physical health care as early adopters. And it requires that our new behavioral health system provide access to recovery support services, such as housing, supported employment and connections to peers.
- *Dual Eligibles health reform*: The dual eligibles demonstration project involves individuals eligible for both Medicare and Medicaid ("dual eligibles"). The demonstration project includes an integrated finance and service delivery care model in which medical, mental health, substance abuse, and long-term care services are purchased through a managed care organization.
- *Recent and pending judicial decisions*: (1) On August 7th, 2014, the Washington State Supreme Court ruled that hospital boarding of individuals in mental health crisis, absent medical need, is unconstitutional. A stay was granted by the Court in September stating that this ruling will go into effect on December 26, 2014; and (2) In October, the courts imposed sanctions on the state healthcare authority regarding delays in performing forensic mental health evaluations. Additional decisions may be forthcoming.

King County, with its robust history of behavioral health innovation and leadership, is uniquely positioned to build on and leverage these reform efforts to deliver the identified outcomes.

Timeline: Start Date: October 2014 – End Date: October 2016

Deliverables: Behavioral Health Strategic Plan

1. Recommend system improvements resulting in a continuum of care that:
    a. Serves consumers across all age ranges, including children and parents;
    b. Reduces demand for involuntary detention;
    c. Increases community alternatives to detention;
    d. Prioritizes mechanisms that prevent behavioral health events from becoming crises;
    e. Ensures appropriate treatment beds available, voluntary and involuntary;
    f. Provides necessary resources to providers, including state and county services; and
    g. Builds on and leverage existing successes.

2. Identify policy or legislative changes that support system improvements and drive toward a continuum of care.

3. Specify how this work links with and furthers existing behavioral health work and endeavors.

4. Develop proposed performance targets and oversight/reporting plans.

5. Respond to King County Council Motion 14225-Reports due
    a. June 30, 2015 Progress report to the Council
    b. January 30, 2016 Progress report to the Council
    c. June 20, 2016 Final Task Force Report to the Council

Motion 14225 states:

> The executive is requested to assist the task force to find short- and long-term sustainable solutions that: increase the use of least restrictive alternatives for individuals in crisis, thereby reducing the demand for involuntary treatment, including the demand for involuntary treatment court services; provide for successful reentry into the community for individuals who have received services from psychiatric hospitals, including mental health and substance abuse treatment; and focus especially on the continuum of prevention and intervention services.
>
> The task force is requested to submit a final report to the executive and the council on June 30, 2016, detailing findings and recommendations on the following matters:
> 1. Identification of services, programs, and protocols necessary for King County to reduce of demand for involuntary treatment services, including involuntary treatment court services
> 2. Identification of the continuum of reentry services from psychiatric hospitals into the community, including mental health and substance abuse treatment services; and
> 3. Identification of prevention and intervention services and least restrictive alternatives for individuals in crisis.
> The task force is requested to provide progress reports to the executive and the council describing the progress and findings of the task force as it develops and reviews recommendations for the final report. The progress reports are due June 30, 2015, and January 30, 2016.

Sponsors:

Office of the Governor
King County Executive Office
King County Council
Department of Community and Human Services

Membership:

This task force focuses on King County solutions, though statewide membership will be sought to address broad policy issues, solicit creative ideas and share recommendations that may be implemented in other communities. Task force members will commit to develop broad partnerships, create bigger and achievable goals, use and share better data and be prepared to take bold action that delivers results.

Subject matter experts or others may be asked to participate in Task Force meetings and or work groups as needed as subject matter experts.

Co-Conveners:	Betsy Jones - King County Executive Office Andi Smith - Office of the Governor
Members:	Kelli Carroll – Department of Community and Human Services Dave Chapman – Director, Department of Public Defense Laura Collins - Harborview Medical Center Chris Imhoff - Division of Behavioral Health and Recovery Darcy Jaffe - Harborview Medical Center David Johnson – Navos Dan Satterberg - King County Prosecuting Attorney Jim Vollendroff - Department of Community and Human Services Chelene Whiteaker - Washington State Hospital Association Dr. Maria Yang – Medical Director, King County MHCADSD
Stakeholders:	King County Executive Office King County Council Office of the Governor Department of Community and Human Services Harborview Medical Center Division of Behavioral Health and Recovery Washington State Hospital Association Washington Community Mental Health Council Law Enforcement Criminal Justice – courts, prosecution, defense Jail Health Services Designated Mental Health Professional Staff

Appendix C: Task Force Membership

Task Force Member	Affiliation	Role
Ron Adler	Western State Hospital	Chief Executive Officer
Johanna Bender	King County District Court	Regional Mental Health Court Judge
Holly Borso	Department of Social and Health Services (DSHS) / Division of Behavioral Health and Recovery (DBHR) / Behavioral Health and Service Integration Administration (BHSIA)	Behavioral Health Program Manager, State Hospital Special Populations
Kelli Carroll	King County Department of Community and Human Services (DCHS) / Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)	Strategic Advisor
David Chapman	Office of the King County Executive	Justice System Improvement Manager
Laura Collins	Harborview Medical Center	Psychiatry Administrator
Lisa Daugaard	King County Department of Public Defense (DPD)	Deputy Director
Charlotte Daugherty	King County Superior Court	ITA Court Program Manager
Mike DeFelice	King County DPD / Civil Commitment Division	Supervising Attorney
Patty Hayes	Public Health – Seattle and King County	Interim Director
Chris Imhoff	DSHS / DBHR	Director
Darcy Jaffe	Harborview Medical Center	Chief Nursing Officer
David Johnson	Navos	Chief Executive Officer
Betsy Jones	Office of the King County Executive	Health and Human Potential Policy Advisor
Rick Lichtenstadter	King County DPD, Defender Association Division	Acting Interim Director
Leesa Manion	King County Prosecuting Attorney's Office	Chief of Staff
Terry Mark	King County DCHS	Deputy Director
Anne Mizuta	King County Prosecuting Attorney's Office, Involuntary Treatment Unit	Deputy Prosecuting Attorney, Senior Specialist
Adrienne Quinn	King County DCHS	Director
Jean Robertson	King County MHCADSD	Assistant Division Director, Regional Support Network Administrator
Dan Satterberg	King County Prosecuting Attorney's Office	Prosecuting Attorney

Task Force Member	Affiliation	Role
Susan Schoeld	King County MHCADSD	Crisis Diversion Program Manager
Ken Schubert	King County Superior Court	ITA Court Judge
Andi Smith	Office of the Governor	Senior Policy Advisor
Gail Stone	Office of the King County Executive	Law and Justice Policy Advisor
Diane Swanberg	King County MHCADSD	Coordinator, Crisis and Commitment Services
Chris Verschuyl	King County MHCADSD	Program Manager
Jim Vollendroff	King County MHCADSD	Division Director
Chelene Whiteaker	Washington State Hospital Association (WSHA)	Policy Advisor, Member Advocacy
Dr. Maria Yang	King County MHCADSD	Medical Director, Managing Psychiatrist

Appendix D: Washington Supreme Court Ruling *In re the Detention of D.W. et al*

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

IN THE MATTER OF THE DETENTION OF: D.W., G.K., S.B., E.S., M.H., S.P., L.W., J.P., D.C., and M.P., Respondents, and FRANCISCAN HEALTH CARE SYSTEMS and MULTICARE, HEALTH SYSTEM, Respondents/Intervenors, v. THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES and PIERCE COUNTY, Appellants.	No. 90110-4 En Banc Filed AUG 07 2014

GONZÁLEZ, J.—Washington State's involuntary treatment act (ITA), chapter 71.05 RCW, authorizes counties to briefly detain those who, "as the result of a mental disorder," present an imminent risk of harm to themselves or others, or are gravely disabled. RCW 71.05.153(1), .230. The initial brief

detention is for the limited purpose of evaluation, stabilization, and treatment, and once someone is detained under the ITA, he or she is entitled to individualized treatment. RCW 71.05.153, .230, .360(2). Pierce County frequently lacks sufficient space in certified evaluation and treatment facilities for all those it involuntarily detains under the ITA. It regularly resorts to temporarily placing those it involuntarily detains in emergency rooms and acute care centers via "single bed certifications" to avoid overcrowding certified facilities. Such overcrowding-driven detentions are often described as "psychiatric boarding." DAVID BENDER ET AL., A LITERATURE REVIEW: PSYCHIATRIC BOARDING 4 (2008). Patients psychiatrically boarded in single bed certifications generally receive only emergent care. After 10 involuntarily detained patients moved to dismiss the county's ITA petitions, a trial judge found that psychiatric boarding is unlawful. We agree and affirm.

FACTS

Our current involuntary civil commitment system has been regularly overwhelmed since it was first enacted by the legislature in 1979. Mary L. Durham & John Q. La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395, 411-12 (1985). By 1981, Western State Hospital, which at the time acted as an evaluation and treatment center, was filled to capacity and refused to accept more patients until it was ordered to by this

court. *Id.* at 412-13 & n.104 (citing *Pierce County v. W. State Hosp.*, 97 Wn.2d 264, 644 P.2d 131 (1982)).

Overcrowding has continued. In early 2013, Pierce County detained the 10 respondent patients before us under the ITA. In most cases, the respondents were initially held in hospital emergency rooms or in local acute care medical hospitals. None of these sites were certified as evaluation and treatment centers under the ITA. In all cases, the county, through one of its designated mental health providers, filed petitions to hold the respondents for up to 14 more days. Several of the involuntarily detained patients moved to dismiss these 14-day petitions on the grounds that they had not been, and believed they would not be, detained in a certified evaluation and treatment facility. On February 12, 2013, Mental Health Commissioner Adams heard the motions to dismiss two of these petitions. At this hearing, the prosecutor informed the commissioner that Pierce County had eight other single bed certifications pending in local medical facilities. Upon learning this, Commissioner Adams set the matter over for an evidentiary hearing on February 27, 2013. Concerned that he lacked necessary briefing and parties, the commissioner invited the Department of Social and Health Services (DSHS) and several of the hospitals who had housed involuntarily detained patients to participate.

One of the witnesses at the February 27 hearing was Nathan Hinrichs, the supervisor of the designated mental health professionals (DMHP) in Pierce

County. Hinrichs testified that once a DMHP determined that someone should be involuntarily detained for evaluation, "we try and locate a bed. We'll call up to five local hospital evaluation and treatment centers to try and find a bed, sometimes more." Clerk's Papers (CP) at 117.[1] If no bed is available, the DMHP would "seek to obtain a single bed cert[ification] to detain them at the community hospital." *Id.* at 118. To do that, the DMHP would fill out a certification form and "fax that to Western State" Hospital. *Id.* Western State Hospital "never asked" why Pierce County was seeking a single bed certification; it would almost always simply approve the request. *Id.* at 119. Indeed, Hinrichs could remember only one time a request was denied: when the county sought a single bed certification in the Special Commitment Center on McNeil Island. Hinrichs also testified that those patients involuntarily held in single bed certifications "are getting less care than they would if they were in an evaluation and treatment center [and] it's actually a more restrictive environment." *Id.* at 124. He testified that on the day of the hearing, there were 11 people in Pierce County held on single bed certifications. The State's witness, David Reed from DSHS's Division of Behavioral Health and Recovery, testified consistently. Reed also testified that the use of single bed certifications had "within the past seven years . . . pretty much exploded and is

[1] While Hinrich did not say specifically those five evaluation and treatment centers he would contact would be certified, the context suggests they would have been.

continuing to increase." *Id.* at 171. After the hearing, Commissioner Adams found that a patient involuntarily detained in a single bed certification "gets no psychiatric care or other therapeutic care for their mental illness" and that the practice of using single bed certifications to avoid overcrowding certified evaluation and treatment facilities is unlawful. *Id.* at 48, 192, 54-55.

Pierce County moved to revise Commissioner Adam's decision. While still technically appearing as an amicus, DSHS challenged the commissioner's power to hear the case and argued that psychiatric boarding to avoid overcrowding certified facilities was allowed by both the ITA and its implementing regulations, especially WAC 388-865-0526. Judge Nelson vacated the commissioner's decision, but she reached the same conclusion in her own extensive written ruling. She also granted the amici's motions to intervene.[2]

DSHS and Pierce County appealed. On the Court of Appeals' own motion, the 10 cases were consolidated and, after the briefs were filed,

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[2] The hospitals' interest in intervening is clear. At the hearing below, the hospital interveners' counsel informed the trial judge:

> We operate three hospitals that have undergone, if you will, single-bed certifications. We have no psychiatrists. We have no psychiatric nurses. We have no orderlies. We have no ability to provide any of the treatment that is mandated under the statute. We are basically warehousing these people, including kids. I mean, we had a kid in the ER at Mary Bridge for 10 days the other day, or last month.

VRP (Mar. 29, 2013) at 16.

transferred to this court.[3] The respondent patients are supported on review by interveners MultiCare Health System and Franciscan Health System; by amici curiae Disability Rights Washington, the National Alliance on Mental Illness Washington, and the American Civil Liberties Union of Washington in one brief; and by amici curiae the Washington State Hospital Association, the Association of Washington Public Hospital Districts, the Washington State Medical Association, the Washington Chapter of the American College of Emergency Physicians, the Northwest Organization of Nurse Executives, the Washington State Nurses Association, SEIU Healthcare 1199NW, and the Washington Council of Emergency Nurse Association in another.

ANALYSIS

We review questions of law de novo and findings of fact for substantial evidence. *Soltero v. Wimer*, 159 Wn.2d 428, 433, 150 P.3d 552 (2007) (citing *Nordstrom Credit, Inc. v. Dep't of Revenue*, 120 Wn.2d 935, 942, 845 P.2d 1331 (1993)). The ITA impacts liberty interests and thus is strictly construed. *In re Det. of G.V.*, 124 Wn.2d 288, 296, 877 P.2d 680 (1994) (quoting *In re Det. of Swanson*, 115 Wn.2d 21, 31, 804 P.2d 1 (1990)).

The State's lawful power to hold those not charged or convicted of a crime is strictly limited. *Oviatt ex rel. Waugh v. Pearce*, 954 F.2d 1470, 1474

[3] The record on appeal was sua sponte sealed by the Court of Appeals under RCW 71.05.620. No one has asked us to consider the propriety of this action.

(9th Cir. 1992) (citing *Baker v. McCollan*, 443 U.S. 137, 144, 99 S. Ct. 2689, 61 L. Ed. 2d 433 (1979)). However, "[a] state has a legitimate interest in treating the mentally ill and protecting society from their actions." *In re Albrecht*, 147 Wn.2d 1, 7, 51 P.3d 73 (2002) (citing *Addington v. Texas*, 441 U.S. 418, 426, 99 S. Ct. 1804, 60 L. Ed. 2d 323 (1979)). Civil commitment is permitted, but the commitment system "must require that an individual be both mentally ill and dangerous for civil commitment to satisfy due process." *Id.* (footnote omitted) (citing *Addington*, 441 U.S. at 426); *Foucha v. Louisiana*, 504 U.S. 71, 80, 112 S. Ct. 1780, 118 L. Ed. 2d 437 (1992)). Anyone detained by the state due to "incapacity has a constitutional right to receive 'such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition.'" *Ohlinger v. Watson*, 652 F.2d 775, 778 (9th Cir. 1981) (quoting *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971)). Patients may not be warehoused without treatment because of lack of funds. "'Lack of funds, staff or facilities cannot justify the State's failure to provide [such persons] with [the] treatment necessary for rehabilitation.'" *Or. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1121 (9th Cir. 2003) (alterations in original) (quoting *Ohlinger*, 652 F.2d at 779).

The ITA itself embraces these principles. It says that "[e]ach person involuntarily detained or committed pursuant to [the ITA] shall have the right to adequate care and individualized treatment." RCW 71.05.360(2). The ITA

also repeatedly provides that those involuntarily detained for evaluation, stabilization, and treatment are to be held in certified evaluation and treatment facilities. *E.g.*, RCW 71.05.150(4) ("The designated mental health professional may notify a peace officer to take such person or cause such person to be taken into custody and placed in an evaluation and treatment facility."), .153(1) (providing that "the designated mental health professional may take such person, or cause by oral or written order such person to be taken into emergency custody in an evaluation and treatment facility"), .210 ("Each person involuntarily detained and accepted or admitted at an evaluation and treatment facility . . ."), .220 ("[a]t the time a person is involuntarily admitted to an evaluation and treatment facility . . ."). There are exceptions, but they are limited.[4]

The act defines "evaluation and treatment facilities" as

> any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, *and which is certified as such by the department.* A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the department or any federal agency will not require certification. No correctional institution or

[4] The ITA does authorize transfer to a chemical dependency treatment facility if the medical staff determine "that the initial needs of the person would be better served" in one or to a hospital if the patient's "physical condition reveals the need for hospitalization." RCW 71.05.210. Those are the only exceptions in the ITA itself for involuntarily detaining someone in a 72-hour or 14-day detention outside of a certified evaluation and treatment facility that have been called to our attention.

> facility, or jail, shall be an evaluation and treatment facility within the meaning of this chapter.

RCW 71.05.020(16) (emphasis added). This definition does not include hospital emergency rooms or acute care centers unless they are specifically certified as evaluation and treatment centers, which no one in this case contends they were. We find that the act itself does not authorize single bed certifications to avoid overcrowding certified evaluation and treatment facilities.

Properly read, the administrative regulations at issue are in accord. The most relevant regulation provides:

> At the discretion of the mental health division, an exception may be granted to allow treatment to an adult on a seventy-two hour detention or fourteen-day commitment in a facility that is not certified under WAC 388-865-0500;
>
> . . . .
>
> (3) The request for single bed certification must describe why the consumer meets at least one of the following criteria:
>
> (a) The consumer requires services that are not available at a facility certified under this chapter or a state psychiatric hospital; or
>
> (b) . . . being at a community facility would facilitate continuity of care . . . .
>
> (4) . . . The single bed certification must not contradict a specific provision of federal law or state statute.

WAC 388-865-0526; *accord* WAC 388-865-0500. The State argues that this rule authorizes single bed certification both when the involuntarily detained patient needs medical care that is not available at a certified evaluation and treatment center and when there is no room in a certified evaluation and treatment center where appropriate treatment would be otherwise available. We disagree. Properly read, this rule allows single bed certifications when, in the exercise of professional judgment, a properly qualified agent of the mental health division determines that there is either a medical justification for involuntarily detaining a patient outside a certified facility or that the single bed certification would facilitate continuity of care. For example, the rule would allow a single bed certification when a patient "requires services that are not available" at an evaluation and treatment center, such as dialysis or chemical dependency treatment. WAC 388-865-0526(3)(a). By its plain terms, this rule does not authorize a single bed certification merely because there is no room at certified facilities with which the county already has a contractual relationship.[5]

The county argues we should show appropriate deference to the professional judgment of psychiatric professionals and not substitute our judgment for theirs. Br. of Appellant Pierce County DMHPs at 22 (citing *Youngberg v. Romeo*, 457 U.S. 307, 322-23, 102 S. Ct. 2452, 73 L. Ed. 2d 28 (1982)). We agree that exercises of professional judgment of qualified

[5] If it did, it may violate both the ITA and constitutional rights of the patients.

professionals are entitled to substantial respect. *See generally Braam ex rel. Braam v. State*, 150 Wn.2d 689, 701, 81 P.3d 851 (2003). We would generally not disturb the decision of a qualified person that a patient had an individual need for services not available at any certified evaluation and treatment center. However, this record does not show that the decisions to involuntarily detain these patients outside of certified facilities was the result of an exercise of professional judgment about the needs of the individual patient. Instead, the record demonstrates that a DMHP did not find room in a certified evaluation and treatment facility and that some person at Western State Hospital approved a request for a single bed certification without knowing whether there was a medical justification for involuntarily detaining that individual patient outside of a certified facility. We find that the ITA authorizes single bed certifications for statutorily recognized reasons individual to the patient, but not merely because there is a generalized lack of room at certified facilities.[6]

CONCLUSION

We affirm the trial judge's ruling that the ITA does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities.

[6] The State and county brought many challenges to the trial judge's authority to hear the case. We find the judge had authority to consider the lawfulness of the county's actions under the ITA and find the other challenges unavailing. Given our disposition, we do not reach the remaining challenges brought by the respondents.

In re the Detention of D.W., et. al., No. 90110-4

González, J.

WE CONCUR:

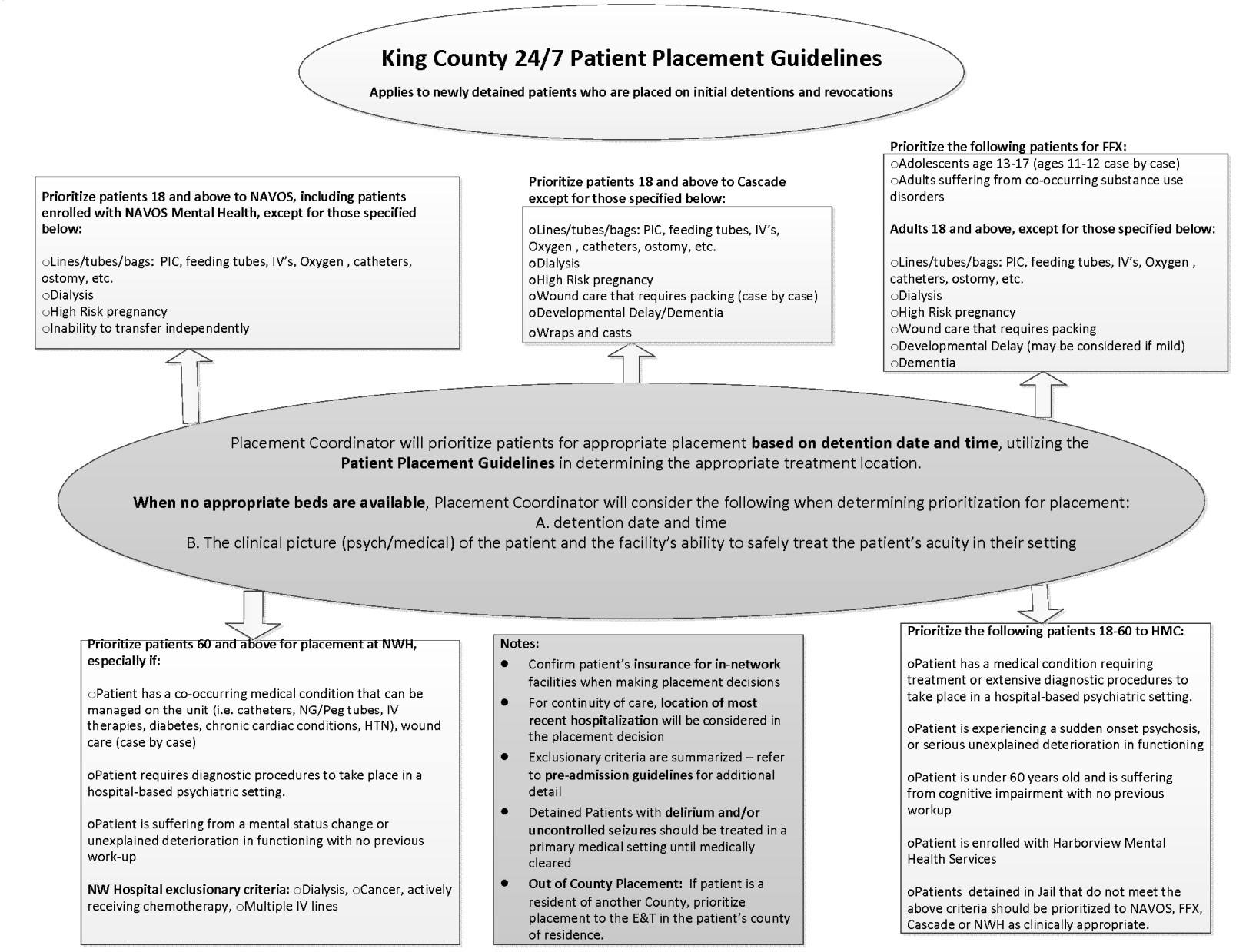
Madsen, C.J.

Stephens, J.

Owens, J.

Fairhurst, J.

Appendix E: Patient Placement Guidelines



Appendix F: Declination Reasons Given by the King County E&T Facilities

Declination Reasons Given by King County Evaluation and Treatment (E&T) Facilities

January – April 2015

The lists below include stated reasons each King County evaluation and treatment (E&T) provided when declining involuntarily detained patients during the period of January 1, 2015 through April 28, 2015. The numbers in the parentheses represents the number of clients who were declined for the stated reason. The list is presented in descending order, meaning that the E&T listed first (Fairfax) declined the most patients.

Fairfax

(5) Client used a wheelchair.
(5) No beds were available.
(4) Client has diagnosis of HIV. (Fairfax requires a lab test, with two-day turnaround, to show that a patient has a certain number of immune cells before admitting someone with HIV.)
(4) Client was not eating and drinking.
(3) Client had "medical issues."
(3) Client had a seizure while in the emergency department (ED).
(3) Client had dementia or similar cognitive problem.
(2) Client was on the "do not admit list."
(2) Fairfax has said that the client is "too high acuity."
(2) Client identified as transgender and no single room was available.
(2) "unknown"
(2) Client was taking methadone(for opiate use disorder).
(2) Client used a cane or walker.
(1) Fairfax thought that the client had abnormal labs.
(1) Client was eight months pregnant.
(1) Client was assaultive in the ED.
(1) Client had cancer.
(1) Client "can't walk."
(1) Client had a chronic lung infection.
(1) Client uses a CPAP machine for sleep apnea.
(1) Client did not provide urine for testing at the ED.
(1) Client had diabetes and was refusing insulin.
(1) Client's labs indicated possible liver problems.
(1) Client had a history of falling.
(1) Client was incontinent.
(1) Client had liver damage.
(1) Client had a brain infection.
(1) Client had multiple sclerosis.
(1) Client needed opiates while in the ED.
(1) Client was not "medically cleared."
(1) Client had partial paralysis.
(1) Client had a traumatic brain injury.
(1) Client reportedly needed wound care, although referring hospital said that this was not the case.
(1) Client had a low blood count.
(1) Client's court date the next day.
(1) Client had chronic kidney disease.
(1) Client's arm was in a cast.
(1) Client had a rape charge.
(1) There was "no staff to accommodate" the client.
(1) Client had a heart rhythm problem.
(1) Client had developmental delay.
(1) Client reportedly had "nursing needs," although referring hospital disagreed.
(1) Client was refusing medications in the ED.

Cascade

(8) Cascade had concerns about client behavior.
(3) Client had "medical issues."
(3) Client was not eating and drinking.
(2) Cascade reported that their units were "too acute" to accept patients.
(2) Client identified as transgender and no single room was available.
(2) Client used a wheelchair.
(1) Client was "inappropriate."
(1) Client was "positive for gangrene."
(1) Client was going through withdrawal from benzodiazepines.
(1) Client couldn't perform activities of daily living independently.
(1) Client had "cardiac issues."
(1) Client had chronic lung disease.
(1) Client used a CPAP machine for sleep apnea.
(1) Client had dementia.
(1) Client had diabetes and was refusing insulin.
(1) Cascade did not pick up the phone to take a referral.
(1) Client's labs indicated possible liver problems.
(1) Client had a history of falling.
(1) Client was incontinent.
(1) Client was deemed "old and frail."
(1) Client was taking blood thinners.
(1) Client had respiratory problems.
(1) Client had a seizure while in the ED.
(1) Client likely had sickle cell disease.
(1) Client was taking buprenorphine, a medication used for opiate use disorders.
(1) Client's arm was in a cast.
(1) No beds were available.
(1) Client reportedly needed wound care, although referring hospital said that this was not the case.
(1) Client had a heart rhythm that was concerning.

Navos

(2) Client had a catheter in place to assist with voiding urine.
(2) "no beds"
(2) Client was not eating and drinking.
(2) Client had paralysis.
(2) Client couldn't perform activities of daily living independently.
(1) Client was deemed "frail."
(1) Client had "medical issures."
(1) Client had concerning findings on an EKG.
(1) Client couldn't swallow.
(1) Client couldn't walk.
(1) Client had dementia and a walker.
(1) Client had diabetes and elevated blood sugars.
(1) No female beds available for female client.
(1) Client had seizures and was refusing medication.
(1) Client had a traumatic brain injury.
(1) Client needed a physical therapy evaluation.
(1) Client likely had sickle cell disease.
(1) Client was refusing cancer treatment.
(1) Client was taking buprenorphine, a medication used for opiate use disorders.
(1) Client's lithium level was concerning for toxicity.

Northwest

(2) Client was not eating and drinking.
(1) Northwest had concerns that the client would go through alcohol detoxification, although referring hospital disagreed.
(1) Client had insurance problems.
(1) Client had an active infection and no single room was available.
(1) Northwest said that the referred client did not have a mental illness.
(1) Client had a history of violence.
(1) No beds were available.

Harborview

(3) No beds were available.
(1) Client was delirious.

Appendix G: Task Force Member Advocacy on Policy Bills

Policy Issue	Bill #	Trends in Task Force Advocacy	Result	Potential Effect on Task Force Work
Response to suicide threats and attempts, including police notification, DMHP response timeline	1448	Expressed concerns about additional workload and timeline requirements.	Pending as of 6/5/15	Unless the work can be contracted out, the new timeline will affect how DMHPs must prioritize cases originating from police.
Assisted outpatient mental health treatment (AOT), including other changes to less restrictive alternative processes and options	1450	Supported giving DMHPs additional means to engage people with mental health treatment prior to inpatient detention. Requested greater clarity regarding outpatient evaluation process. Requested attention to current behavior in AOT criteria. Requested sufficient funding.	Signed into law	Provides a new structure for providing involuntary care without any inpatient hospitalization. Creates a menu of revocation and modification alternative options less intensive than rehospitalization. Likely to decrease inpatient utilization via earlier intervention, but will increase DMHP workload and ITA Court filings.
Raise tobacco purchase age	1458	Supported raising tobacco purchase age to 21. Also supported compromise age increase to 19.	Pending as of 6/5/15	Would reduce access to tobacco in high schools, reduce addiction, and improve population health.
Certificate of restoration of opportunity (CROP)	1553	Supported removing legal barriers to employment and housing for individuals in recovery who have criminal histories.	Did not pass	The lack of restorative alternatives increases this population's contact with multiple service systems. This subject will be revisited for future advocacy.
Integrated mental health and substance abuse commitment, and integrated administrative provisions	1713	Supported integrated crisis systems. Provided technical amendments to the bill. Supported continued study of this issue. Requested sufficient funding. Supported provisions relating to integration of advisory boards.	Pending as of 6/5/15	Integrating the involuntary commitment system would allow greater access to involuntary care for individuals whose crisis need arises from substance abuse or co-occurring disorders. Board integration would support BHO development.

Policy Issue	Bill #	Trends in Task Force Advocacy	Result	Potential Effect on Task Force Work
Telemedicine	5175	Supported payment reforms designed to encourage the practice of telemedicine.	Signed into law	May create opportunities to deliver care in more efficient or effective ways.
Court review of family member petitions to overturn DMHP decision	5269	Supported family member involvement in ITA process in principle. Expressed concerns about timelines and process; proposed amendments. Requested sufficient funding.	Signed into law	It is unknown what volume of petitions or overturned cases will result or how this will affect Court and DMHP workload.
Crisis intervention training for peace officers	5311	Supported expanding crisis intervention training, including at least some training for all new officers.	Signed into law	May increase the prevalence of crisis-trained officers, and the demand for diversion resources.
ITA timeline adjustments and process changes	5649	Supported exempting time prior to medical clearance from DMHP response times, and deciding cases on merits rather than on timeline violations. Sought definition of medical clearance. Supported allowing DMHPs to presume SBC approval and move on to other cases. Supported reports to the state whenever a person is unable to be placed in an E&T or on a legal SBC.	Signed into law	DMHPs will be able to respond to crises more efficiently. Fewer people in need of involuntary treatment will be left without care as a result of timeline violations. May increase inpatient utilization. Consistent statewide data about the scope of psychiatric boarding will be generated and reported publicly.
Removing imminence standard from ITA	5687	Opposed this expansion of detention criteria as unnecessary given existing non-emergent detention option.	Did not pass	Major potential effect on DMHP and ITA Court workload averted.

Appendix H: Task Force Member Advocacy on Budget Items

Budget Item	Budget	Trends in Task Force Advocacy	Result	Potential Effect on Task Force Work
Capital funding for E&Ts and hospital bed conversion	Capital	Supported funding for these strategically critical inpatient resources that will directly increase treatment access.	Pending as of 6/5/15	These funds would help to support a sizeable increase in inpatient capacity in our community, which could result in further increases in direct placement to E&Ts.
Capital funding for secure detoxification facilities	Capital	Supported funding for these new resources to enable successful implementation of an integrated ITA.	Pending as of 6/5/15	Unless funded, this may be an area for future Task Force advocacy. These resources, if created, would result in more responsive treatment for people with acute substance abuse care needs.
Non-Medicaid mental health and substance abuse funding	Operating	Requested sufficient investment in services that are ineligible for Medicaid reimbursement. Provided amendment language to ensure that cuts designed to reduce reserves do not unfairly impact King County.	Pending as of 6/5/15	Further cuts in this area could limit funds available for crisis response including DMHPs and associated court services, as well as less restrictive alternatives such as residential mental health treatment, and may result in cuts to state-funded outreach programs.
Program for Adaptive Living Skills (PALS) funding elimination	Operating	Requested restoration of funding for specialized treatment environments to serve this very high risk population.	Pending as of 6/5/15	This would leave approximately 46 of King County's dangerous and very difficult to place mental health clients without appropriate community treatment. These individuals will use community hospitals, jails, and state hospital beds more often as a result.

Budget Item	Budget	Trends in Task Force Advocacy	Result	Potential Effect on Task Force Work
Increased rates for substance use disorders providers	Operating	Supported equity in rates between Medicaid and non-Medicaid clients to assist community providers.	Pending as of 6/5/15	This would enable outpatient substance abuse treatment providers to move clients onto Medicaid without absorbing a financial loss. This will help support a broad-based provider network as behavioral health integration proceeds.
Criminal Justice Treatment Account (CJTA)	Operating	Requested restoration of planned cuts affecting treatment access for criminal justice-involved substance abuse clients.	Pending as of 6/5/15	This would reduce access to treatment for criminal justice-involved clients, including Drug Court participants.
Mental health Medicaid rate reduction to lower limit of actuarially allowable range	Operating	Provided clarifying language to ensure that the cost to King County is minimized.	Pending as of 6/5/15	This would affect other areas more than King County, but still will result in reductions to core Medicaid funding that is used throughout the continuum of care.
Sufficient funding for judicial operations	Operating	Requested restoration of dramatic proposed cuts.	Pending as of 6/5/15	Cuts to judicial operations would limit the ability to respond to overcrowding at the ITA Court or serve the additional cases that will result from recent changes to the ITA law.